The Lived Experience of Midwives' Ethical Dilemmas in Conscientious Objection to Abortion Using Interpretative Phenomenological Analysis

Jacqueline Richards

A thesis submitted in partial fulfilment of the requirements of Liverpool John Moores University for the degree of Doctor of Philosophy

October 2024

Acknowledgements

It has been my privilege and a pleasure to be supervised for this Doctorate by Dr Grahame Smith, Dr Julie Connolly, and Dr Tina South. Thank you for believing in me and never giving up or allowing me to. Your advice, encouragement and guidance have proved invaluable and allowed me to develop professionally and personally beyond what I ever thought possible. Special mention is made also to Professor Valerie Fleming and Dr Clare Maxwell, who saw my potential, created opportunity, and supervised in the early stages. I feel indebted to Doctoral Academy, library, IT, and skills department at Liverpool John Moores University, who formalised my ideas and provided a very inspired and enjoyable experience. I hope I make you proud.

I have been fortunate in my PhD journey to have been accompanied by the superb Dr Becky Self. With endless kindness and humour, she has been an all-round sounding board. Our daily discussions have provided the foundation of my position on conscientious objection. I wish you well in your career and hope the world soon recognises your stellar brilliance, my friend.

Primarily, I describe myself as a midwife so due acknowledgements must recognise the clinical team at Warrington & Halton Hospitals, especially Matron Ann Goodwin and Sister Nikki Webb, who supported my application, cheered me on and facilitated my sabbatical.

Doing justice to the unspoken voice of midwives, thank you to all my participants for the insight into the phenomenon of conscientious objection. Also, to fellows at the Royal College of Midwives, International Confederation of Midwives and Neil Stewart Associates. Your contribution saves lives, and, I am convinced, impacts in a positive way the lives of millions of women in distress. Remember, together we are stronger as we endeavour to provide a safe, legitimate, equitable and legally endorsed service. Your compassion and commitment to professional values is a fine example. Thank you to researchers in the field and publishers who gave permission to use their work.

Of course, it would not all have been possible without my rock – my parents, family and friends. Friends like Gillian Forster inspiring my education made me who I am. All my achievements are illuminated by your light, standing on the shoulders of giants. Thank you for reassuring me and telling me as I grew (something I now realise),

“You are a child of the universe, no less than the trees and the stars; you have a right to be here. And whether or not it is clear to you, no doubt the universe is unfolding as it should. Therefore, be at peace with God, whatever you conceive Him to be. And whatever your labours and aspirations, in the noisy confusion of life, keep peace in your soul. With all its sham, drudgery, and broken dreams, it is still a beautiful world.”

The Desiderata, Meditations of Descartes (1596-1650)

Thank you, Mum, for showing me what Safe Motherhood means. Rest in peace, Dad, knowing now I am a doctor. Dedicated also to the memory of Ana Maria Acevado and Catholic nun, Sister Consilia.

Contents

Acknowledgements 3

Abstract 13

Declaration 14

List of Tables 15
List of Figures 15
List of Reflexivity Pit stops 15

Chapter 1 - Introduction 17

1.1 Comment on Terminology 18
1.1.2 Outline of the Thesis 19

1.2 Background 21

1.2.1 The Global Context of the Research Problem 21
1.2.2 The UK Situation and Focus of the Study 23
1.2.3 The Research Problem Restated: Justification for the Study 29
1.3 Addressing Knowledge Gaps 31
1.4 Introduction Conclusion 34
1.5 Summary 34
1.6 Aim 35
1.7 Objectives 35

Chapter 2 – Literature Review 36

2.1 Search Strategy Introduction 36
2.1.1 The Review Approach and its Rationale 36
2.1.2 Structure of the Literature Review 37
2.1.3 Overarching Literature Review Aim 38
2.1.4 Secondary Review Questions 38
2.1.5 Literature Review Strategy 38
2.1.6 The Use of Keywords 39
2.1.7 Inclusion Criteria 40
2.1.8 Exclusion Criteria 41

2.1.9 Critical Appraisal Approach ... 41
2.1.10 Assessing the Quality of the Studies ... 43
2.1.11 Characteristics of the Studies ... 43
2.1.12 Revisiting the Literature Review ... 44
2.1.13 Search Strategy Conclusion ... 46
2.2 A Closer Look at What Conscientious Objection Comprises ... 46
2.3 Causes of Conscientious Objection ... 47
2.4 Appearances of CO: Fink et al.'s (2016) Spectrum of CO ... 48
2.5 Support for the Legal Right to Conscientiously Object ... 51
2.6 Is Conscientious Objection Reasonable for Service-Users? ... 52
2.7 The Approach to CO by Wicclair (2011) ... 54
2.8 Literature Review by Themes ... 54
2.8.1 Theme 1 - Practising Midwife, Practising Religion ... 54
2.8.2 A Faith-Based and Ideological Look at CO ... 55
2.8.3 Roman Catholicism ... 56
2.8.4 The Church of England (C of E) ... 56
2.8.5 Hinduism ... 57
2.8.6 Islam ... 58
2.8.7 Judaism ... 59
2.8.8 What is Conscience and How Is It Different to Moral Reasoning? ... 60
2.8.9 The Relevance of Conscience to Healthcare ... 61
2.8.10 Conscience in the Main Abortion Arguments ... 64
2.8.11 Case-by-Case Moral Reasoning ... 66
2.8.12 Institutional Conscience ... 68
2.8.13 Aggregate Duties of Healthcare Professionals ... 70
2.3 Theme 2 - Navigating with a Moral Compass ... 71
2.3.0 The Importance of Morality in Midwifery ... 71
2.3.1 'Downplaying' The Role of Moral Integrity ... 72
2.3.2 Theories of Moral Development ... 73
2.3.3 Value Judgments ... 75
2.3.4 Moral Imagination ... 76
2.3.5 Moral Conscience ... 78
2.3.6 Relativism ... 78
2.3.7 Objectivism and Popper's Principle of Rationality ... 79
2.3.8 Constructionism ... 79
2.3.9 Subjectivism ... 80
2.3.10 Perspectivism ... 80

2.3.11 Moral Complicity ... 81
2.4 Theme 3 - Fearing Reviving, Surviving and Thriving ... 82
2.4.1 The Idea of Personhood ... 83
2.4.2 When Does Life Begin? ... 84
2.4.3 Potentiality ... 88
2.4.4 A Future Like Ours, A Future Life of Value? ... 89
2.5 Theme 4 - Being Torn Between Wearing Two Hats ... 90
2.5.1 Ethical Theory Applied to Conscientious Objection Decision-Making ... 91
2.5.2 Deontological ... 91
2.5.3 Teleological (or Consequentialist) ... 92
2.5.4 Virtue-based ... 93
2.5.5 Ethical Principles ... 96
2.5.6 Beneficence ... 96
2.5.7 Non-maleficence ... 97
2.5.8 Justice ... 98
2.5.9 Autonomy ... 99
2.5.10 Ethical Codes & Standards of Professional Behaviour ... 101
2.5.11 Ethical Dilemmas ... 103
2.5.12 Moral Reasoning, Choices, and Ethical Decision-making ... 106
2.6 Theme 5 - Two Signatures and The Escape Clause ... 109
2.6.1 Rights to Freedom of Conscience ... 109
2.7 Theme 6 - The Right Midwife Delivering the Right Care ... 111
2.7.0 Duty of Care ... 111
2.7.1 Understanding Consent ... 113
2.7.2 Advocacy and Role Conflict ... 114
2.7.3 Paternalism and How Empowerment Overcomes It ... 115
2.7.4 Emotional Labour and Moral Work in Ethical Decision-making ... 117
2.7.5 Links to Models of Maternal Mortality ... 120
2.7.6 Working Rights or Obligations? The Role of Statutory Bodies ... 121
2.7.7 BMA (2019b) Position Paper ... 122
2.7.8 Adjudication and Tribunals ... 124
2.7.9 The Rights of Students & Training ... 125
2.7.10 A Feminist Bearing on the Topic ... 126
2.7.11 Doing Science as a Feminist ... 129
2.7.12 Arguments Against Conscientious Objection ... 132
2.7.13 Literature Review Conclusion ... 134

Chapter 3 – Methodology 136

3.1 Introduction 136
3.2 Ontology 137
3.3 Epistemology 137
3.4 Rationale for a Qualitative Paradigm 139
3.5 Alternative Methodologies 140
3.5.1 Ethnography 140
3.5.2 Grounded Theory 140
3.5.3 Hermeneutic Phenomenology 141
3.5.4 Thematic Analysis 142
3.6 The Contribution of IPA 142
3.7 Insider/Outsider Perspectives 145
3.8 IPA's Philosophical Foundations 146
3.8.1 Phenomenology 147
3.8.2 Hermeneutics 148
3.8.3 Idiography 151
3.8.4 Empathy in Capturing the Lived Experience 151
3.8.5 Symbolic Interactionism 152
3.8 Limitations of Using IPA 156
3.9 Conclusion to Methodology Section 158

Chapter 4 – Method 160

4.1 Study Design 160
4.2 Justification for the Approach 160
4.3 Limitations of Using Semi-structured Interviews as a Method 161
4.4 Planning the Study and Ethical Approval 161
4.5 Inclusion/Exclusion Criteria 162
4.6 Recruitment 163
4.7 Sampling Advantages and Limitations 163
4.8 Sample Size and Its Justification 164
4.9 Homogeneity and Participant Characteristics 166
4.10 Data Collection 168
4.11 Verifying the Data 168
4.12 Transcription 170
4.13 Theoretical Model of the Thesis: Smith, Flowers, and Larkin (2022) 172

4.13.1 Initial Exploratory Noting 173
4.13.2 Emergent Personal Experiential Themes 173
4.13.3 Devising Group Experiential Themes 173
4.14 The Practice of Data Analysis 173
4.15 The Double Hermeneutic Approach 175
4.15.1 Arguments for or Against the Double Hermeneutic Approach 176
4.16 The Use of Pen Portrait 'Thumbnail' Summaries 177
4.17 IPA and Data Saturation 178
4.18 The Rationale for Using NVivo 179

Chapter 5 - Quality 182

5.1 Ensuring Quality 182
5.1.1 Sensitivity to Context 183
5.1.2 Commitment and Rigour 183
5.1.3 Transparency and Coherence 183
5.1.4 Impact and Importance 183
5.2 Reflexivity as an Issue of Quality 184
5.3 Rationale for Reflexivity 184
5.4 Quality Markers of Nizza, Farr and Smith (2021) 186
5.4.1 Constructing a Compelling, Unfolding Narrative 187
5.4.2 Developing a Vigorous Experiential and/or Existential Account 188
5.4.3 Close Analytic Reading of Participants' Words 189
5.4.4 Attending to Convergence and Divergence 190

Chapter 6 - Findings 191

6.0.1 Introduction 191
6.1 Theme 1 – Practising Midwife, Practising Religion 193
6.1.1 Thou Shalt Not Kill 195
6.1.2 Reinforcing Attitudes to Procreation 196
6.1.3 Let Her Without Sin Cast the First Stone 198
6.2 Theme 2 - Navigating with a Moral Compass 199
6.2.1 An Issue of Conscience 200
6.2.2 Thought and Moral Processes 201
6.2.3 Mentally Traumatised 203
6.3 Theme 3 - Fearing Reviving, Surviving and Thriving 205
6.3.1 Encountering a Diagnosis Minefield 205

6.3.2 Living a Full, Full Life 207
6.3.3 Medical Marvels At 22 Weeks 210
6.3.4 Conscientious Objection Crises at the Cusp of Life 210
6.4 Theme 4 - Being Torn Between Wearing Two Hats 212
6.4.1 Putting Things into a Box 213
6.4.2 Ensuring the Patient Comes First 215
6.4.3 Respecting Differing Views 216
6.4.4 Being a Midwife in the Room – What? When? Who Should I Tell? 218
6.5 Theme 5 - Two Signatures and the 'Escape Clause' 221
6.5.1 Is It Legal? 221
6.5.2 Understanding the Conscience Clause 224
6.5.3 A Fresh Look at Conscience Policy 226
6.6 Theme 6 - The Right Midwife Delivering the Right Care 228
6.6.1 Achieving a Harmonious Balance 229
6.6.2 Changing Job Descriptions 230
6.6.3 Managing CO Since 1967 233
6.7 Findings Conclusion 235

Chapter 7 - Discussion 238

7.0.1 Introduction 238
7.0.2 The Concept of CO Crises 238
7.1 Theme 1 - Practising Midwife, Practising Religion 239
7.1.1 Thou Shalt Not Kill 241
7.1.2 Reinforcing Attitudes to Procreation 244
7.1.3 Let Her Without Sin Cast the First Stone 246
7.2 Theme 2 - Navigating with a Moral Compass 248
7.2.1 An Issue of Conscience 249
7.2.2 Thought and Moral Processes 251
7.2.3 Mentally Traumatised 254
7.3 Theme 3 - Fearing Reviving, Surviving and Thriving 255
7.3.1 Encountering a Diagnosis Minefield 256
7.3.2 Living A Full, Full Life 258
7.3.3 Medical Marvels of 22 Weeks 260
7.3.4 CO Crises at the Cusp of Life 260
7.4 Theme 4 - Being Torn Between Wearing 'Two Hats' 262
7.4.1 Putting Things into a Box 263

7.4.2 Ensuring the Patient Comes First 264
7.4.3 Respecting Different Views 266
7.4.4 Being a Midwife in the Room - What? When? Who Should I Tell? 267
7.5 Theme 5 - Two Signatures and the 'Escape Clause' 269
7.5.1 Is it legal? 270
7.5.2 Understanding the Conscience Clause 271
7.5.3 A Fresh Look at Conscience Policy 272
7.6 Theme 6 - The Right Midwife, Delivering the Right Care 274
7.6.1 Achieving a Harmonious Balance 275
7.6.2 Changing Job Descriptions 277
7.6.3 Managing CO since 1967 278
7.7 Model of CO Definition Explained 281
7.7.1 Model of CO Definition 283
7.8 A Slippery Slope Argument? 289
7.9 Illustration of the Model of CO Definition 290
7.10 Gender Considerations in the Data 297
7.11 An Alternative Perspective of Conscientious Objection 299
7.12 Spectrum of CO Views 301
7.13 The Unique Contribution of this Work 304
7.14 Aims and Objectives Revisited 305
7.15 Discussion Conclusion 308

Chapter 8 - Conclusion 313

8.1 Implications of the Research 318
8.2 Limitations of the Study 319
8.3 Recommendations for Further Research 320
8.4 Policy Recommendations 321
8.5 Summary of Findings/Key Points 322

References 324

Appendices 386

Appendix 1: UREC Minimal Risk Registration; Ethics Approval 21/NAH/013 387
Appendix 2: Recruitment Flyer 389
Appendix 3: Participant Information Sheet 390
Appendix 4: Consent Form 396

Appendix 5: Interview Schedule 398
Appendix 6: Search Strategy 399
Appendix 7: Critical Appraisal Skills Programme Review 405
Appendix 8: Reasons Why Women Have Abortions (Chae et al. 2021) 412
Appendix 9: Overview of Broad Reasons Used to Argue For or Against CO (Fleming et al. 2018) 422
Appendix 10: Spectrum of CO Views 428
Appendix 11: A Case Study: Ana Maria Acevedo 429
Appendix 12: Case Level Pen Portrait 'Thumbnail' Summaries 431
Appendix 13: Transcription 443
Appendix 14: Abbreviations 456
Appendix 15: Glossary 458
Appendix 16: Conferences/Presentations 463
Appendix 17: Publications 464

Abstract

Background: For some practitioners required professionally to partake in the 73 million abortion procedures carried out worldwide each year (WHO 2023), participation can sometimes be a source of distress which has brings them into conflict with their employers (Fleming et al. 2018; Zaami et al. 2021), colleagues (Adenitire 2016; Boama 2018), service-users (Self 2023; Self et al. 2023) and with governments (Oderberg 2018). 'Conscientious objection' (CO) is an opportunity to exercise freedom of conscience by refusal to partake in contentious procedures to which practitioners may have a moral repugnance, invoking legal rights to decline involvement, for whatever reasons. Meeting societal assumptions about what midwives do when pregnancy is unintended, unwanted, or unsustainable creates dilemmas. Providing universal healthcare, realising reproductive justice, and supporting bodily autonomy for the individual may be challenging. Whose rights are right? The debate is polarising.
The primary concern is that patients obtain the care they need. Critics believe CO potentially disrupts this (Fiala and Arthur 2014; 2017; Schuklenk and Smalling 2017; Savulescu and Giubilini 2018). Despite commitments to woman-centredness, midwives are caught up in policy-less discrepancies and misinterpretations. Midwives' perspectives in decision-making remain scant. Knowledge of the mechanisms of moral reasoning remains particularly elusive to explain a concept that essentially is a personal matter of conscience. Insight which this research seeks to provide.
Methodology and findings: Using Interpretative Phenomenological Analysis (IPA), most useful in under-researched topics, I explored the lived experiences of 15 midwives to gain an insight into dilemmas related to their making ethical sense of CO. Semi-structured interviews generated data, analysed with Smith, Flowers, and Larkin (2022) IPA approach. Six Group Experiential Themes (GETs) emerged: 'Practising midwife, practising religion', 'Navigating with a moral compass', 'Fearing reviving, surviving, and thriving', 'Being torn between wearing two hats', 'Two signatures and the escape clause' and 'The right midwife, delivering the right care'.
Discussion and conclusion: Accommodation is inconsistently practised in maternity environments, often non-transparent, ad hoc, and disorganised suggesting poor understanding of rights provisos made in section 4 (i) 'the conscience clause' of the 1967 Abortion Act. Data paints a complex picture: objector-led, responding to contemporary 'CO crises' and traumatising. A conceptual model to structure operationalisation of procedures and a framework of moral reasoning were devised. As abortion-defenders, participants nevertheless voiced support for CO on the condition that safety and care were not impaired by the realisation of dissenting colleagues' rights.

Declaration

I confirm this original work is my own. No part of the work I refer to in this programme of research has been submitted in support of an application for another degree or qualification of this or any other institute of learning.

Signed…………………………………………………

List of Tables

1. Three Perspectives (Tooley et al. 2009: ii) pg. 64-65
2. Theory of Conventional Moral Development (Kohlberg 1958) pg. 73
3. Accounts of Personhood (Mackintosh 2014) pg. 83
4. Professional Responsibility Model of Obstetric Ethics (Chervenak, McCullough and Brent 2011) pg. 105
5. Four Markers for Evaluating Quality in IPA Research (Nizza, Farr and Smith 2021) pg. 187
6. A Typology of Meaning (Smith 2019) pg. 189
7. Group Experiential Themes pg. 191
8. Framework 'How Do Midwives Morally Reason?' pg. 253

List of Figures

1. Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) Diagram pg. 42
2. A Hermeneutic Circle Showing the Literature Review Process pg. 45
3. One Example (Savulescu 2020) pg. 50
4. Heinz Dilemma (Kohlberg 1958) pg. 74
5. The Violinist's Dilemma (Jarvis-Thomson 1971) pg. 87
6. Integrated Model of Patient Care (Varkey 2021) pg. 103
7. Model of Conventional and Alternative Approaches to Conscience and Participation in Abortion Care (Czarnecki et al. 2019) pg. 119
8. The Gender Continuum (Caro 2009) pg. 131
9. Philosophical Underpinnings of IPA pg. 147
10. Field Notes and First Draft Colour-Coded Exploratory Noting pg. 174
11. Double Hermeneutic Loop pg. 176
12. The Iterative Process (Finlay 2013) pg. 185
13. The Blessed at the Gate to Heaven with St. Peter (1467-1471) by Hans Memling pg. 246

List of Reflexivity Pit stops

1. International Comparisons - Delegates of the Congress of the ICM pg. 25
2. Who am I? pg.28
3. Ethical Stance pg. 95
4. My Experience of Conscientious Objection pg.146
5. Post Data Collection, What Have I Learned? pg.149
6. Post GETs – My Axiological Position on Abortion pg.155

7. My Overseas Experience and Backstreet Abortion pg.159
8. Methodology and Method pg. 180
9. Post-thesis – What Do I Think Constitutes Care? pg. 312
10. Post-thesis – What Do I think Constitutes the Gold Standard? Pg.322

Chapter 1 - Introduction

The 1967 Abortion Act makes grounds for abortion in England, Scotland, and Wales if there exists:

- Risk to the life of the pregnant woman.
- A necessity for abortion to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- Risk of injury to the physical or mental health of the pregnant woman or any existing children of her family (up to a term limit of 24 weeks of gestation); or
- Substantial risk that if the child were born, it would "suffer from such physical or mental abnormalities as to be seriously handicapped".

At that time, the 1967 Abortion Act was heralded as landmark legislation – part of a package which looked to realising sexual and reproductive health (SRH) rights. Its purpose,

"To amend and clarify the law relating to termination of pregnancy by registered medical practitioners," (Legislation 2024)

has been largely realised, successfully all but eradicating backstreet abortion. The Act has ensured those practitioners carrying out the procedure are more legally regulated and held to account for their practice. Countless maternal mortalities have been prevented and the lives of millions of women have been released from the burdens of unintended pregnancies. Since 1967, abortion has become the most common gynaecological procedure – 214,869 UK abortions were performed 2021 (ONS 2021) - the highest number since the Act's introduction.

The focus of this study is to explore the lived experience of UK midwives moral reasoning, making ethical sense of a clinical dilemma, conscientious objection. By definition, a clinical dilemma is taken to be a situation in which a difficult choice has to be made between two or more alternatives, especially ones that are equally undesirable, creating repugnancy or moral distress. Rights not to partake are covered by law in section 4 (i), the so-called conscience clause. This protects UK health workers if participation in abortion violates their personal values, for whatever reason. Although an NHS – provided service, legally endorsed, the impact of exercising freedom of conscience is interpretated in different ways by different practitioners.

1.1 Comment on Terminology

The fact that at least two of the participants (Maria and Peter) lead lengthy discussion around the very controversial and loaded nature of abortion-related terminology urges some mention of the use of words and the scope of their meanings. The different connotations between termination of pregnancy (taken to mean the feticide part of the process, ending the pregnancy and basically the life of the fetus encapsulated or 'housed' as Maria states within the service-user), and abortion (its expulsion) are distinguished as the former implying by the actions of another and the latter a more physiological sense. The concept may be made more complex by associated lexicon used by professionals – spontaneous abortion, therapeutic abortion, incomplete abortion, threatened abortion or illegal abortion, for example, each adding its own different take. 'Abortion' was chosen as the preferable term to termination of pregnancy, because of its accentuation on a more complete process than participation in fetal demise itself. This is in keeping with World Health Organisation and UNFPA terminology.

Almost all the participants at interview, pick up on similar controversies between terms for the growing offspring - a clump of cells, a fertilised egg, an ovum, a fetus, and a developing baby are all witnessed in the texts and indeed used interchangeably by both participant and interviewer alike. A stronger sense of the idea of personhood is perhaps associated with more human baby-like terms, rather than the onus on the life being alien, or a foreign body. This is contentious. It belies the voice of the participant, in their storytelling as well as unpicks the linguistic metaphor whilst sense and meaning making. For the large part, the term fetus is preferred for in utero pregnancy.

The use the gender-neutral term ‘service-user’ is no less open to debate. Perhaps this a more consumerist term used in abortion-seeking with the onus being on the patient being some kind of clientele. As a vessel of the pregnancy, alternative terms like mother reflect more than the physical nature of childbearing because, of course, there is much more to motherhood than childbirth. Although criticised for being unfashionably Paternalistic, the affectionate use of 'lady' appears recurrently amongst interviewees, presumably a term of endearment though not a comment of sexual identity.

Finally, what meaning are we to make of the use of terminology to describe the participant? This could be confusing, as 'participation' means something entirely different in abortion than at interview in research. In fact, clarification of the nature of participation and its interpretation and application in practice are included in the study's

research questions. Also, the word 'participant' as only 'part' may be associated with other similar connotations, then can we really be sure the relationship is truly 50/50. Similarly, to promote reading ease, a list of abbreviations is included in Appendix 14.

1.1.2 Outline of the Thesis

The thesis is comprised of eight chapters, brief details of which are outlined below:

Chapter one introduces the research idea and provides some context in relation to the 1967 Abortion Act, the global context of conscientious objection and the UK situation: the focus of the study. The research problem is restated, justifying the study. How knowledge gaps are addressed by the aim and objectives finally concludes this section.

Chapter two involves a more detailed review of the literature surrounding the topic area. This will help to contextualise the study and highlight gaps in knowledge around conscientious objection, applying ethical theory to Maternity and sexual/reproductive health services at large.

Chapter three provides detail regarding the theoretical and methodological background to the study and the justification for the use of IPA, its underpinning theoretical foundations and limitations. It also addresses the ontological and epistemological position of the thesis. In addition to the three tenets of phenomenology, Hermeneutics and idiography, symbolic interactionism is added as another analytical strategy.

Chapter four describes the study design and method used in the study. This chapter includes a description of the settings and discussion of the sample, including inclusion/exclusion criteria, recruitment, and the research population. Some of the ethical issues arising in the conduct of the research are considered. Justification for the IPA model of analysis Smith, Flowers, and Larkin (2022) is central to this chapter.

Chapter five gives insight into aspects of quality. There are two criteria used, Yardley (2008) and Quality Markers of Nizza, Farr and Smith (2021). Why and how they ensure a rigorous study is examined. Reflexivity, a theme running concurrently through the thesis, is discussed in more detail in this chapter.

Chapter six discusses the findings of the research, presented according to the six elicited group and twenty-one personal experiential themes from data collected: Practising Midwife, Practising Religion, Navigating With a Moral Compass, Fearing

Reviving, Surviving and Thriving, Being Torn Between Wearing Two Hats, Two Signatures and the ‘Escape Clause’ and The Right Midwife Delivering the Right Care.

Chapter seven findings within the themes are accompanied by an alongside discussion. This chapter explains the ‘Model of CO Defintion’ and ‘Framework of Moral Reasoning’. Gender considerations, the lived experience of ethical dilemmas amongst male midwives and a ‘Spectrum of CO Views’, as an analytical tool are elaborated herwithin.

Chapter eight presents the conclusion to the thesis, along with implications, limitations and recommendations for practice and further research.

1.2 Background

1.2.1 The Global Context of the Research Problem

The Abortion Act's pioneering impact was to prove far-reaching, internationally as well as in a UK-centred context, suggest Finer and Fine (2013: 585). Many countries have used the Abortion Act as a blueprint for liberalisation of abortion laws, regulation, and decriminalisation (Rahman et al. 1998). The evidence is clear: legislative developments are linked to the status of women, they appear to state,

"There is a global trend toward the liberalisation of abortion laws driven by women's rights, public health, and human rights advocates. This trend reflects the recognition of women's access to legal abortion services as a matter of women's rights and self-determination and an understanding of the dire public health implications of criminalising abortion. Nonetheless, legal strategies to introduce barriers that impede access to legal abortion services, such as mandatory waiting periods, biased counselling requirements, and the unregulated practice of conscientious objection, are emerging in response to this trend. These barriers stigmatise and demean women and compromise their health."

What motivates practising midwives to decline participation is poorly understood. The dilemmas which create so much controversy lack prominence in the literature. The World Health Organisation (WHO) (2021) calculate that worldwide 1:3 women undergo the abortion procedure by the age of 45, arguably demonstrating some societal acceptance. Where does this fit with moral justification by midwives, whose professional values support empowerment and realisation of autonomy, but who themselves do not endorse abortion? Rahman et al. (1998) here class objection as a stigmatising and demeaning barrier to women "compromising health". Fifty years on since its mandate provided for legal abortion provision (that's around 73 million induced abortions worldwide each year), what is the basis for the enduring phenomenon that is conscientious objection? Six out of 10 (61%) of all unintended pregnancies, and 3 out of 10 (29%) of all pregnancies, end in induced abortion. That feature alone contributes to midwives reasoning – in an age of contraception, is there a need for some balance, objectors question.

Just under half of these remain unsafe, resulting in complications like injury, haemorrhage, and sepsis – a stark reminder of why legal abortion needs to be supported. The rate of all abortions increases in high rather than in low-income regions.

Among the 25 million unsafe abortions, 8 million are carried out in the least safe or dangerous conditions. Over half of all estimated unsafe abortions globally are in Asia. 3 out of 4 abortions that occurred in Africa and Latin America were unsafe. The risk of dying from an unsafe abortion was the highest in Africa. Around 7 million women are admitted to hospitals every year mostly in low-income settings the result of unsafe abortion (WHO 2021). Despite the headway made in the Safe Motherhood Initiative since its launch in 1987, the fact remains that worldwide approximately 19 million women are estimated annually to need treatment for complications of unsafe abortion. Concerted action is needed. Abortion accounts for 4.7 – 13.2% of all pregnancy related deaths (WHO 2021) making it a key cause of maternal mortality.

Disparities remind us of the dangers of policy in which legal abortion is not viewed as a substantive part of health care. WHO's position is that safe abortion must be provided or supported by a trained person using WHO recommended methods appropriate for the pregnancy duration. Almost every abortion death and disability could be prevented through sexuality education, use of effective contraception, provision of safe, legal induced abortion, and timely care for complications (WHO 2023). This thesis maintains there is a place for recognised and regulated freedom of conscience within this. Greater understanding of the perpetual philosophy surrounding conscientious objection's Catch 22 could streamline access ultimately, avoiding delays. Any negation in patient care is deemed wrong.

Despite its frequency, abortion remains controversial, far from popularly received in the public consciousness (Newport 2022). Discussion around abortion comes to a head, fueled in the media by Populist reactions to events impacting globally, driving the research area, and making calls for clarification ever more urgent. Anti-abortion violence (Stewart 2023), and campaigning (Clarke 2022) arbitrary criminalisation of providers (Ambast et al. 2023) and outrage at the imprisonment of one service-user who accessed telemedicine deemed illegal (Thomas 2023), establishment of clinic buffer zones (Loffhagen 2022) and the reversal of the decision made in the US legal case of Roe versus Wade (Jones and Chiu 2023) are all examples of recent attention sparking debate around the permissibility of abortion.

Add a covid pandemic to the mix and the worldwide situation swiftly has become catalytic. Global maternal and fetal outcomes have worsened during the COVID-19 pandemic, with an increase in maternal deaths, stillbirth, ruptured ectopic pregnancies, and maternal depression. In these health provision tight spots, pressures are more

acutely on midwives to appreciate their obligations and responsibilities to 'do no harm'. It follows ethical decision-making places each practitioner with a predicament, a heavy moral burden, when faced with this prodigious need if their values contravene these trends and strategic priorities to tackle,

"The urgent need to prioritise safe, accessible, and equitable maternity care within the strategic response to this pandemic and in future health crises" assert Chmielewska et al. (2021: 759).

A worldwide conversation has ensued on how best to ensure abortion coverage, availability, and accessibility (WHO/UNFPA/ICM 2021; Jones and Chiu 2023). In the US, Ireland, Poland, Sub-Saharan Africa, Latin America, Scotland, Italy, Sweden, ethical questions around conscientious objection have been raised as part of this debate. Policy includes a role for midwives in abortion to deal with the pandemic-related crisis affecting women and girls in many ways, including increased gender-based violence and reduced access to essential sexual and reproductive health services, leading to increases in maternal mortality, unintended pregnancies, unsafe abortions, and infant mortality (WHO/UNFPA/ICM 2021). Compounded by a lack of uniformity, covid-19 restrictions have widened inequities (Moreau et al. 2021) so it remains more imperative than ever to assert what constitutes the right care delivered by whom. The annual cost of treating major complications from unsafe abortion, estimated at US$ 553 million (WHO 2021), ensures that safe abortion features strongly in statutory politico-economic debate, however. It makes economic sense to provide a safe, legal abortion as part of a sexual and reproductive health need so why the anathema of some midwives' disagreement. In this study, UK midwives articulate their views on non-endorsement by some professionals and tell of their own lived experience of dilemmas in their ethical decision-making. Although none proved outwardly to be objectors, a few were abortion providers, so the lived experience centres on what leads to a decision to participate in abortion or not – reflections common to all practitioners, everywhere.

1.2.2 The UK Situation and Focus of the Study

In the moral imagination, these dramatic international and historical contrasts bear weight on midwives' moral reasoning. The message, driven home in the UK by popular media – television programmes like 'Call the Midwife' remind us of the abhorrence of backstreet abortion and reinforce that the 1967 Abortion Act largely eradicated many offences against the person. In the UK, abortion is a legitimate, universal, and legally endorsed right to a comprehensive service funded by the taxpayer. NHS constitutional

values commit to fair and equitable principles – from each according to their abilities, to each according to their needs, free at the point of delivery (NHS 2021). For these reasons, conscientious objection (CO) is shrouded in controversy. In a specialism where safety could be being risked by their non-participation, we will examine what motivates midwives to decline involvement in care given the magnitude of this demand and unmet need.

Amongst UK practitioners tasked with carrying out their professional duties, patterns of current uptake may also bear weight on their decision to participate. There were 3,370 disability-selective UK abortions in 2021, 859 of these were for Down's syndrome, an increase of 24.0% from 693 in 2020. 40 of these were for cleft lip/palate (a surgically reversible condition), an increase of 14.3% from 35 in 2020 (ONS 2021). The perspective on whether the abortion is deemed 'right', when and for whom may depend on the abortion's justification. Others believe that the reason for the abortion ought not to matter. The over-riding criteria of the Abortion Act, designed to be all-encompassing, has in practice proved equally divisive, resulting in misinformation, inconsistencies, discrimination and discrepancies, lobbyists claim (Clarke 2022; Self 2023).

1. Reflexivity Pit-Stop – International Comparisons at the ICM

At the Congress of the International Confederation of Midwives attended in Bali (June 2023, see Appendix 16), an interesting discussion sparked up between midwives surrounding various presentations. Ireland's delegation of midwives gave their account of providing the first ever abortion on 1st January 2019. In 2012, Irish abortion law received worldwide attention on the death of Savita Halappanavar, who had been denied an abortion while suffering a septic miscarriage. This increased calls to repeal the Eighth Amendment. Legislative provisions were discussed at a Citizens' Assembly and at an Oireachtas committee in 2017, both recommending substantial reform which framed the referendum in May 2018 prompting decriminalisation. My colleagues told of a heavy security presence and bodyguards outside the operating theatre (not an entirely new departure to me following inner city training). Fiercely abortion-defenders, the team seemed cautious at first of my thesis' motivations, but we agreed on the benefits of a moderation in freedom of conscience as the way forward. I reflect that a lot of people misinterpret conscientious objection as a staunch pro-life opinion – which is slightly different and this impacted on my thesis since it made me keen to stress accommodation as a balanced concept without conflict, that is fair and respects persons in support of bodily autonomy. Their recollections contrast sharply against the UNFPA-facilitated presentation by the delegation from the USA who practised midwifery in Texas where abortion has been outlawed – right up to Midnight. A trigger law passed in July 2021 that came in effect on August 25, 2022, as a consequence of the U.S. Supreme Court's 2022 decision *Dobbs v. Jackson Women's Health Organization* overturning *Roe v. Wade* means that the law makes no exception for pregnancies resulting from rape or incest. The change in legal status has prompted expecting mothers with health complications to leave the state or forced them to give birth while jeopardizing their health. Midwives told of threats to their security of person and how incensed the environment had become in which they practised.

Comparing the two extremities, I was very much struck by how women and their families are often caught up in the politicking that surrounds abortion and even the unethical enactment of objection. The experience of reaching out to colleagues across the globe, whose abortion service provisions are very disparate, made me realise that midwives, too, are often caught up in an abyss. Comparisons to the UK situation abounded – an NHS flagship. Against this backcloth, practitioners are called upon to be advocates for those women who may be rendered vulnerable and even more in crisis. A voice for the voiceless.

Everyone has their own view on CO and to extent to which midwives maintain a recognised right to legitimately withdraw their professional services, like the right to strike. It may seem a kind of contradiction for members of a profession whose values and ethos are widely assumed to maintain Hippocratic-type commitments to preserve life, eradicate health disparities, promote welfare, and support woman-centredness. In this context, this study asks how midwives become conflicted and torn by these ethical dilemmas. It aims to explore how midwives make ethical sense of CO as a clinical process, speculating about their conjectured part in the abortion, 'If not me, then whom? If not now, then when? If not within a healthcare remit, then how?'

Public opinion features more on the balance between the morality of abortion and opponents, a disputatious association, than CO as a legal right for midwives. Little is publicly known about what UK midwives think and what sways their practice. Together these factors help justify why a peaceful solution like accommodation of CO is needed.

Abortions must be performed to keep people safe but the moral and ethical questions raised in exacting abortion as a policy mean that there are still philosophical and theological arguments to consider, particularly around when the abortion is conducted (in medical terms, ideally before the 12th week). For some people, their position remains that an abortion is an abortion, not a pro rata procedure, however (or whenever) it is conducted. Others maintain abortion is a right, to be freely accessed as part of healthcare: a personal matter and a civil liberty in which there is no place for third party interference.

For the proportion of professionals whose compunction makes them feel that they are doing something complicit with a moral scruple or contrite, what motivates them to object? The thesis will touch upon how being a midwife compared to other specialisms makes their experience of conscientious objection unique. Regardless of the axiological positions of the participants, epitomised in the 'Spectrum of Views' on conscientious objection, the insight into moral mechanisms and thought processes provided by these UK midwives will illuminate how the decision is ethically reasoned and balanced. According to universally held professional values, it will be highlighted that more unites us as practitioners than divides us. The strategy to positively impact on high-quality midwifery care on women and families is detailed in the State of the World's Midwifery (WHO/UNFPA/ICM 2021: iv) which states,

"Investing in midwives facilitates positive birth experiences and safe and effective comprehensive abortion services, improves health outcomes, augments labour supply,

favours inclusive and equitable growth, facilitates economic stabilisation, and can have a positive macroeconomic impact."

2. Reflexivity Pit-Stop – Who Am I?

Mostly, as a working-class, white, middle-aged woman, who has lived through the emergence of more than one wave of Feminism, I adopt a largely post-Modernist, liberal Feminist perspective. I was brought up Protestant and this has helped (but may be coloured) my theological understanding of some of the spiritual aspects of being a 'practising midwife, practising religion'. Although not strictly ranked, this was to prove the most predominant theme. My faith impacted on my research decisions because I was sensitive to some of the religious dictum which struck me as electrifying pearls in the data and as such, I readily picked up on the elements of Christian ethics, as vocalised by participants. I tried to maintain a healthy regard for the theological aspects of research questions and not dismiss as hocus pocus or sweep under the carpet these reflections. For example, by including a glossary, I recognised that not all readers may be familiar with some concepts, or phraseology. In doing so I drew the distinction with Roman Catholicism. Part of achieving this balance, was to give parallel importance to data which transcended religion, alongside data which did not. Having lived in a non-Christian country, I am perhaps more aware of other cultures, but working overseas has reasserted my beliefs in the sanctity of life and ideas of human dignity, making stronger an appreciation of dilemmas in midwifery. The struggle against poverty and its impact on health strongly informs my perspective on conscience and that I have witnessed the worst effects of backstreet conditions drives my research. This motivates me to advocate for change. I see there are a lot of vacillating areas but my position as clinician and researcher is one that rests predominantly in favour of CO rights yet accepting of the need for abortion provision. To be pro-CO does not necessarily equate to an abhorrence of all matters related to abortion. Weighted by its own merits and respectful of personal autonomy, I do not see my role to judge others, including my colleagues. These are principles which steer my research, based on findings. I don't have my own pro-life agenda, but I did try to maintain a healthy regard for its sympathies. My position did not change in the course of the research, but I became more confident in arguing the nuances of an abortion-defence. I was shocked by many of the statistics.

Despite the velocity with which, in just over 50 years, hundreds of thousands have come to access UK services annually under its remit, critics focus on the redundant nature of the 1967 Act, viewed as unfit for purpose, heavily gendered (Amery 2014) and better suited to a Victorian age (Regan and Glasier 2017). Although the 1990 Human Fertilisation and Embryology Act addressed concerns (when it lowered legal limits of abortion from 28 to 24 weeks), advances in medical technology urge re-examination of the issues which leave significant numbers of practitioners conflicted to the point they object to their involvement. Largely, the focus of dilemmas rests on the redefined age of viability which challenges ancient beliefs around what constitutes human life and when it begins. The sands of sexual and reproductive health are shifting and for midwives practising in austere healthcare environments, so the context of midwifery is in a state of flux. In the absence of policy, midwives are heavily reliant on internal mechanisms, allocating scarce resources, but how these decisions are initiated and on what basis remains elusive.

Impacting freedoms has been associated with infringements on the rights of practitioners, who have perennially questioned societal assumptions about their professional role (Steel 2008). Amongst an increasing proportion of practitioners, there exists growing dissatisfaction (Sheldon 2016), a dissatisfaction extending chasms between professional groups. Thus, philosophical, and theological questions determining policy on whose human rights prevail have meant the debate around CO to abortion remains powerful, emotive, and controversial (Chavkin 2017; Pellegrino 2002).

1.2.3 The Research Problem Restated: Justification for the Study

Whilst the ground-breaking nature of the Abortion Act succeeded in achieving its primary aim (to regulate practitioners and outlaw unsafe practice), the skyrocketing of abortion rates was largely unanticipated. Despite the legal provision made within the Act (in section iv, sub-clause 1) to protect rights to conscientiously object, there remains an increasing proportion of practitioners for whom involvement in procedures poses ethical dilemmas. Although the abortion service has generally become more streamlined, availability for those patients who encounter conscientious objection remains a concern. Safety, interference with exercising rights to freely access healthcare and non-realisation of bodily autonomy is a trajectory that many argue is an unacceptably burdensome infringement of civil liberties.

Linked to the status of women, the demand for abortion has driven a “global trend toward the liberalisation of abortion laws” (Finer and Finer 1998: 585) yet the Abortion

Act's 1967 criteria are sometimes deemed inadequate to meet the contemporary requirements of public health, abortion provision and policy in relation to the protection of objectors. Criticisms of the Act not only consider legalities. As out-dated, gender-loaded and not reflecting changing health, it is deemed incapable of meeting society's current needs for a number of reasons:

1. The shifting sands of sexual and reproductive health pose challenges for objectors, faced with dilemmas unenvisioned and unencountered by their 1967 counterparts. Increasing complexity in the cases midwives deal with blur lines between a life to be saved and what otherwise may be seen as an abortable fetus. Whether a pregnancy is described as unintended, unwanted and/or unsustainable reflect how controversial abortion issues can be, which renders conscientious objection even more taboo.
2. Neonatology science and advances in medicine mean more babies are being saved at younger gestations. Pushing the boundaries of viability has incurred medico-legal implications, in terms of redefining and dealing with extreme prematurity, but also philosophical, in terms of what constitutes human life.
3. Extended roles and responsibilities, an integral part of increasingly autonomous midwifery practice, bring a proportion of advanced practitioners into contact with pregnancies that may otherwise be at risk of aborted.
4. The expectations of service-users, alongside societal attitudes, have rendered assumptions ambiguous about professional obligations, what midwives do and what they ought to be able to object to.
5. What leads one midwife to conscientiously object and another not to is poorly understood. Although predominantly theological in origin, as a concept, freedom of conscience is much wider than exclusively religious. Nonetheless, the ethical decision-making which can lead to delays potentially impacting on care requires closer inspection. Exploring freedom of conscience to appreciate how rather than why midwives, as a distinct specialism, object could resolve worst case scenarios highlighted in the case study (see Appendix 11) and above by Finer and Fine (1998).

Just to recap, we have looked at the circumstances that more than ever lead midwives to be faced with more complex ethical dilemmas. Where the thesis fits in this debate will now be examined.

1.3 Addressing Knowledge Gaps

In the strongly RC Brazil, Menezes' (2009) study showed overall there remains a need for studies on the contribution of in-service provision by *midwifery* staff. Here is where this thesis may contribute to addressing the knowledge gap: understanding the impact of moral reasoning amongst those practitioners who feel they cannot. On what basis are ethical decisions rationalised? In fostering streamline accommodation of those needs, a harmonious balance of regulated rights is being advocated.

Will (2013a; Will 2013b) implies that part of the quandary associated with CO is in its lack of clarification in law. What is a person is not defined in the US constitution, especially in its earliest biological stages of development. For Will, the personhood movement implicates reproductive choice in three aspects – infertility treatment, contraception as well as abortion – each dealing with different beings conceptually, legislatively as well as physically which affects how midwives define and reason their interventions. In application of ethical principles to practice, liaison between medicine and the courts and closer definition of the deprivation of futures elsewhere is called for (Kuflik 2008; Nucci 2009; Marquis 1989) so the thesis adopts a distinctly medico-legal slant.

Scientific advances ensure the appearance of new ethical dilemmas is probably infinite. Romanis (2020a; 2020b) points out how new technologies have changed the conception of when life begins, discussing what constitutes a person and how this is changing in contemporary medicine and law. She poses age old, theological questions, most perplexing of all. Despite differing views in medicine of the developing human being, in its temporary existence within the uterus, the fetus has no legal rights and protections, which are only assigned at birth. UK law, she acknowledges, is "unambiguous" that the fetus has no legal personality.

The whole arrangement seems to call for transparency in the mechanisms of decision-making, and open acknowledgement of contrary views. Harris et al. (2016) support suggestions that associated taboos, prejudicial attitudes and societal norms accentuate the complexities associated with moral decision-making and expression of freedom of conscience. A thesis of this nature is intended to cross divides and open the debate.

Ben-Moshe's (2019) summary of the literature on conscientious objection presents two key problems related to claims of morality which remain unresolved:

1. Justification: which conscientious objections in medicine are justified, given the practitioners' genuineness of the objection?

2. Complicity: how does one respect the practitioners' claim or conscience and patients' interests, without leaving practitioners complicit in perceived or actual wrongdoing?

Ben-Moshe advocates bringing professionals' CO into the public domain, with multi-disciplinary "Uber CO Committees" – if patients were referring themselves then this may cut out the middleman and ease some of the burden experienced in the case studies (Self 2023), but solutions like this need to be evaluated. According to Ben - Moshe (2019: 404), so far,

"Answers to the questions of what justifies CO in medicine in general and which specific objections should be respected have proven to be elusive".

The evidence is clear: abortion has led to a considerable reduction in deaths from unsafe abortion, yet ethical dilemmas do remain in ensuring a service is comprehensive when reproductive justice is realised for the individual. Mclean et al. (2019: **1**) argue,

"The law makes the door slightly open, health workers become important in deciding who gets access to safe services and who doesn't, thus creating considerable ethical dilemmas."

Discretion based on patients meeting a criterion affects accessibility. "Reasonable or unreasonable" demarcation relies heavily of subjective value judgments, McClean et al. suggest, itself a dilemma. "Moral grey zones" where the distinction between the morality of an abortion and the legality are poorly understood. Conscientious objection based on those distinctions is even more complex and less fathomable. This is the focus of this UK based study and its main contribution – insight into this reasoning amongst members of the multi-disciplinary team whose roles are much wider than anticipated by architects and 1967 law-makers. Addressing these limitations, WHO (2022) suggests, "will create an enabling environment".

Interpretative Phenomenological Analysis (IPA) is deemed the most effective methodology to achieve this. IPA originated in and is widely applied in psychology

(Smith 1996). It is said to work best in human and health studies, (Charlick, Pincombe, McKellar, and Fielder, 2016) understanding under-researched concepts, like conscientious objection, which are complex and contested (Bacon et al. 2020). Its value is often unrealised in organisational studies, too (Gill 2014). Because of its emphasis on idiographic depth and interpretation, IPA will enable us to see conscientious objection through a phenomenological lens as it is perceived and practised by the practitioners themselves. Exploring the lived experience of dilemmas, moral reasoning and ethical decision-making will be a novel departure – using IPA for the first study of its kind. Phenomenologists look at the phenomenological experience as formative, in-formative, re-formative, trans-formative, per-formative and pre-formative (as defined by Van Manen 2007), giving significance to meanings. Facilitating sense and meaning making of freedom of conscience puts the participant at the heart of scholarly activity (Van Manen 2007),

"Not unlike the poet, the phenomenologist directs the gaze toward the regions where meaning originates, wells up, percolates through the porous membranes of past sedimentations—and then infuses us, permeates us, infects us, touches us, stirs us, exercises a formative affect." (Van Manen 2007: 12)

IPA brings rigour to conscientious objection, what is essentially a subject with ill-defined scope and limitations where parameters of the midwife's role merge with other professions and psychology merges with other disciplines. IPA is a relatively recent research development and adapts well to a dynamic field, like conscientious objection, where practice is indistinct and inexplicit. Researchers must focus upon the context-dependent life worlds of participants, contingent upon social, historical, and cultural factors (Eatough & Smith, 2008). Psychologists often distinguish between qualitative research used for 'Big Q' and 'little q' questions. One is set against a wider, background and the other involves deductive meaning, with pragmatic, mechanistic or descriptive features. The heuristic difference in data type, offered up by Kidder and Fine (1997), is an example of how IPA fills in the gaps, another reason to opt for IPA, suggest Motta and Larkin (2023). As a new departure in a changing context, IPA in this study will address the obscured understanding of CO where vagueness and blurred lines leave primary duties to the patient unfulfilled.

1.4 Introduction Conclusion

Arguments for conscientious objection are rights-based: fundamental principles in respecting persons' autonomous rights to self-determination upheld in common law and statute. No-one can be made to do something, nor ought they to be which freedom of choice activists claim applies as much for the service provider as user. The argument against conscientious objection is that the rights of the majority to access public health and be treated equitably should over-ride those of the individual practitioner. So, who's right is right? Are these constraints of liberty a self-interest or an infringement of entitlements? Who bears the greatest consequences? Therefore, the following thesis aims to focus on what predicaments puzzle a certain proportion of midwives in dealing with unintended pregnancy, using an interpretative phenomenological lens for the first time to gain an appreciation of the distinct perspective of this psychological and moral concept.

1.5 Summary

Although the Abortion Act largely set out what it was aimed to achieve: the eradication of unsafe practices through legalisation, medical advances and the main swell of public opinion have changed the background against which the procedure is set. As shown, neonatology science has redefined the gestational age of viability alongside changing perceptions of what comprises a disability. When accompanied by new clinical techniques, this has implications for the rights of midwives, whose perspective is only just being considered within their extended, autonomous roles. Advanced practice is more likely to bring them to ethical dilemmas and encounter moral challenges.

The Act's 'success' in terms of dramatic reductions in maternal mortality, is not without implications for moral conscience, inherently difficult to gauge. For a proportion of practitioners who question societal assumptions about what they will do (and what they are entitled not to do), the ethical decision-making is often non-transparent, participation-driven, and crisis-led. The opportunity to express freedom of conscience, whilst acknowledged as a potential for harm, has created inconsistencies and discrepancies in what should be an equitable service, freely accessible and universally available.

The responsiveness of IPA as a research methodology makes it well suited to explore these issues, as shown, making sense of midwives making ethical sense of conscientious objection as a clinical process. IPA is committed to the systematic

exploration of personal experience (Tomkins, Brooks, and King 2017) in an iterative way (Finlay 2013). To achieve these aims and objectives, a review of the literature will be undertaken which will examine theoretical perspectives in the field of CO and the contribution of different commentators to the wider debate.

1.6 Aim

To explore midwives' lived experience of ethical dilemmas presenting in CO to abortion using interpretative phenomenological analysis (IPA).

1.7 Objectives

- To make sense of midwives making ethical sense of conscientious objection as a clinical process.
- To identify what is the lived experience of moral reasoning and decision-making for midwives when required in employment to partake in abortion procedures.
- To explore midwives' ideas for improved practice in relation to what constitutes participation in the abortion process.
- To disseminate findings to ensure ways to accommodate CO whilst providing abortion services as part of accessible, legal, and equitable healthcare.

Chapter 2 – Literature Review

2.1 Search Strategy Introduction

The vast yield of literature reiterates how many attempts have been made through the ages in a range of diverse fields to bring enlightenment to complex moral reasoning surrounding conscientious objection to abortion. The range of literature reflects the breadth of CO views and how little consensus exists between often disparate commentators. The controversy makes for a multi-dimensional literature review woven of colourful ideas born of several disciplines. Because the subject area is so dynamic, answers are no clearer today that when Socrates' paradoxes questioned about the nature of knowledge, justice, morality, and virtue[1].

2.1.1 The Review Approach and its Rationale

Notwithstanding, a thorough integrative review of the literature was conducted. This is defined as a unique methodology that produces a synthesis of knowledge and its applicability (De Souza et al. 2010). An integrative review provides a broader summary of the literature and includes findings from a range of available research designs. It gathers and amalgamates both empirical and theoretical evidence relevant to a clearly defined problem or phenomenon. It is the only approach that allows for the combination of diverse methodologies, so is well suited to the multi-perspectives of IPA. Applying an integrative review afforded opportunity to develop a more holistic understanding of the topic, to present the state of the science, and to contribute to theory development. In fact, with its diverse data sources, the integrative review has been advocated as important for evidence-based practice initiatives in nursing (Hopia et al. 2016). The rationale for adopting this hybrid approach is to methodically address theory, to thus learn by using a combination of strategies about a wide range of perspectives, characteristic of conscientious objection. Indeed, a body corpus of established medico-legal, philosophical, theological, and psychological thinking materialised relating to the many dimensions of conscientious objection. In order to draw comprehensive, yet reliable conclusions (Dhollande et al. 2021), the integrative review still needs to be transparent and rigorous (Remington & Toronto, 2020). Where gaps in the body of

[1] There are three Socratic paradoxes. They are: first, that no man desires evil, all men desire the good; second, that no man who (knows or) believes that an action is evil does it willingly--on the contrary, all the actions that a man does willingly he does with a view to achieving some good; and, third, that it is better to suffer injustice at the hands of others than to do unjust acts oneself.

knowledge are identified, the contribution of this piece of work cascades to have its most effective impact. It proved to be broad in scope but narrow enough to be manageable.

There are lots of alternative approaches, but these were discounted on the basis that an evidence synthesis review of this nature is more likely to cover a wider 'reveal' or more thoroughly yield both qualitative and quantitative results. According to Greyson et al. (2019: 1),

"A high quality (systematic) review search has three core attributes; it is systematic, comprehensive, and transparent."

This review attempts to adhere to that Gold Standard. Whilst the review itself is not a systematic review, a systematic approach to retrieval of the literature was undertaken, as advocated by Bedwell (2012: 32). Despite the popularity of the systematic review, however, the flexibility afforded meant findings were more easily revisited in Hermeneutic tradition in the integrative approach as a modified framework (Whittemore and Khafl 2005). Gaps identified gaps in the literature can be addressed through an alternate search and screening strategy, suggest Greyson et al. (2019). It follows, therefore, that this discovery is more likely in the search strategy of choice. Although the more truncated timeline of the narrative approach did possess some appeal, it was ultimately deemed too scant as a screening tool. The focus of such a review can be limiting suggest Collins and Fauser (2005). The structured integrative approach brought consistency to a somewhat disparate material.

First, the organisation of the chapter, then the strategy for identifying articles to be included, detail of the evidence and how it was sourced.

2.1.2 Structure of the Literature Review

The structure of the literature review will be in six parts in keeping with themes elicited from midwives' data in the findings (see page 191) to present the systematic examination of what others say on the subject, before exploring practical considerations raised by participants themselves. A recap of developments will establish where the debate currently stands, with revelations in conscience-based refusal. Briefly summarised, these centre on healthcare professionals' understanding of their rights in respect of freedom of thought, conscience, and expression (compared to other human rights generally) and midwives' perspectives (as opposed to other members of the

healthcare team where information is scant) surrounding involvement in abortion procedures (where understanding of what constitutes participation is fragmented).

2.1.3 Overarching Literature Review Aim

To examine evidence surrounding the ethical dilemmas midwives encounter in the process of morally reasoning their participation in abortion procedures using IPA as a research methodology.

2.1.4 Secondary Review Questions

- How can IPA be applied to throw light on the lived experience of moral reasoning associated with conscientious objection?
- How can literature be identified for evaluative comment and critical appraisal on the subject of conscientious objection to abortion, in favour or against?
- What informational sources can be located related to sexual and reproductive health services and ethical decision-making in respect of lived experience of dilemmas thereof?
- How can a rounded appreciation of the current body of knowledge in respect of the methodological principles of IPA draw on commentary, scientific papers, and grey literature?
- In applying an integrative approach to conducting a search strategy as part of a 'qualitative evidence synthesis' which is the most comprehensive selection of the keywords?

2.1.5 Literature Review Strategy

In keeping with the method recommended by De Souza et al. (2010), there were six stages of the integrative review process: preparing the guiding question, searching, or sampling the literature in an abstract-focused way, data collection, critical analysis of the included studies, discussion of results and presentation of the integrative review using an Endnote library.

Primarily a variety of databases were searched including PubMed/Medline, CINAHL, EMBASE: Excerpta Medica, Cochrane Collection Plus, Global Health Library, Tripdatabase.com, Ebsco.com, Scopus and PsychINFO. A hand search and internet search of the databases of all relevant journals (Elsevier, Wiley, Science direct, Taylor and Francis Online and Biosis Previews) were also undertaken. The databases of professional regulatory and advisory bodies (NICE, NMC, Royal College of Midwives

(RCM), Royal College of Nursing (RCN), British Medical Association, American Medical Association (AMA), International Pharmaceutical Abstracts, and Nursing Reference Centre Plus) proved very beneficial. In Google scholar mostly, (but also by personal communication within workshops and the IPA Group), all work by Professor V. Fleming, M.Wicclair and Jonathan Smith were identified, then the reference lists of all relevant papers were hand searched and links to related papers and citations were followed where available. Other trade sources WHO/PAHO, United National for Family Planning Association (UNFPA), Department of Health (DoH) National Health Service (NHS), Public Health England (PHE), National institute for Health and Care Excellence (NICE), Office for National Statistics (ONS), Nursing and Midwifery Council, RCM/RCN, Ethos, Pro Quest (Theses') produced grey literature, reports, advisory papers, and guidance documents. The initial search took place in 2019-2020, with further searches ongoing in an attempt to identify any subsequent new literature, through alerts on Academia.edu and Researchgate.net, particularly relevant in this grey literature. In order to keep the review current and give a sense of the contemporary changes afoot within the field, The Times, The Sunday Times, The Independent, The Daily Telegraph, The Daily Express, The Daily Mail and The Guardian in the UK were checked weekly; in the US – The Washington Post, The Chicago Tribune). In addition to reputable newspapers, I made the most of social media – YouTube, LinkedIn, and Twitter. I signed up for the service provided by the UK parliament 'They Work for You', using the key phrases 'abortion' and 'conscientious objection'. Appendix 6 illustrates all types of literature, sources of information, using which search term and how the lucrative yields were produced.

2.1.6 The Use of Keywords

Insofar as a search strategy is an organised and targeted structure of key terms used to search a database, the Boolean search strategy combined key concepts of the study's search question in order to retrieve accurate, algebraic results.

The search strategy accounted for all possible search terms, keywords and phrases truncated and wildcard variations of search terms. The purpose is to narrow down to the most relevant and more specific evidence. Both keyword, phrase searching, and truncation techniques (midwi = *midwi*fe, *midwi*ves, *midwi*fery) were employed. Additionally, the use of medical subject headings (MeSH) terms, ensured a comprehensive vocabulary, used as a thesaurus to facilitate retrieval of documents from different origins.

Keywords Midwives; abortion; termination of pregnancy; ethics/law; conscientious objection; freedom of choice; sexual and reproductive health; IPA; lived experience

Keywords make the most of automated search engines of software systems' response on the Web to a user's query, but they need to well-selected and aligned to the research questions to keep the search focused and optimised to the main concepts. When deciding how to choose keywords, I was mindful of the potential for skewifting the data by search engine bias. In this field, this task was made more complex by emerging new vocabulary like abortion-defender (previously pro-choice) and abortion critic (also known as pro-life). The criteria for keywords included relevance, comprehensiveness and succinctness. In identifying those terms which most summed up what I wanted to say, I highlighted the research question's skeletal components to streamline the study's focus and keep it on track. As I began searching, I experimented and tried alternative terms, discovering better, more rounded synonyms. I used different spellings, sometimes linking concepts. Always I used quotation marks for more than two simultaneous words ("termination of pregnancy" AND "conscientious objection"). This increased the number of results but decreased the number of less relevant ones.

2.1.7 Inclusion Criteria

- Papers with aims or debate related to conscientious objection, dilemmas, and ethical decision-making.

- Papers relating to midwives or other healthcare professionals, including nurses, neonatal staff, doctors, general practitioners, anaesthetists, pharmacists, and maternity support workers.

- Papers relating to conscientious objection any healthcare setting in any country.

- Papers written or translated into English.

- Primary or secondary research papers.

- Opinion pieces

- News items to show contemporary developments within the research field.

2.1.8 Exclusion Criteria

- Papers not written or translated into English.

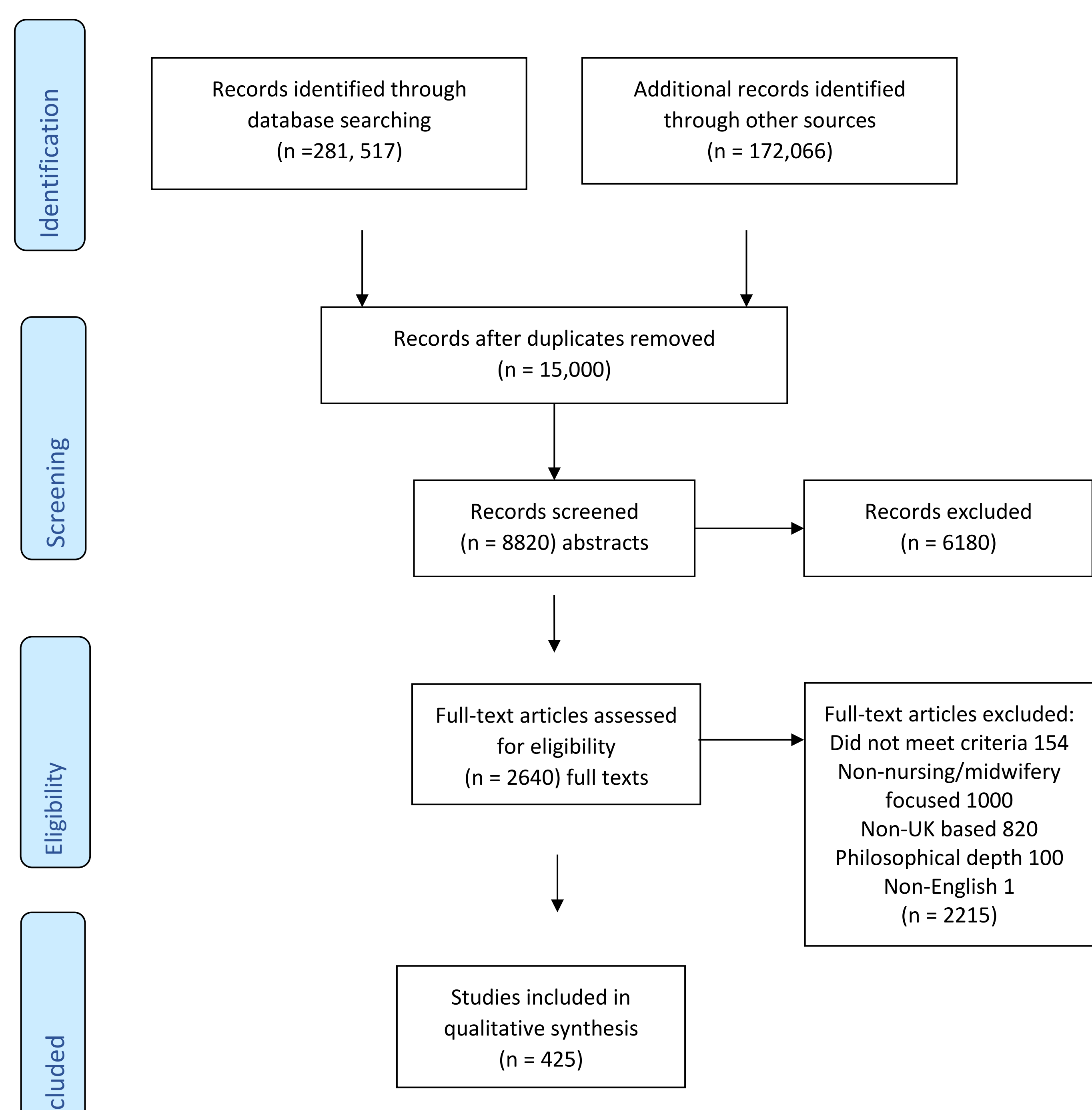
- Papers non peer reviewed.

2.1.9 Critical Appraisal Approach

The Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) diagram (Figure 1) devised by Lockwood, Munn, and Porritt (2015) for the Joanna Briggs' Institute highlights the process undertaken in identification of articles to include in the literature review. As a tool, the purpose is to summarise evidence methodically relating to the efficacy of articles so as not to diminish the research's value (Liberati et al. 2009) or reinterpret studies (Lockwood, Munn, and Porritt 2015). Authors maintain an a priori framework brings standardisation, accuracy, and reliability,

"Qualitative synthesis informs important aspects of evidence-based healthcare… Meta-aggregation is most transparently aligned with accepted conventions for the conduct of high-quality systematic reviews … philosophically grounded in pragmatism and transcendental phenomenology." (Lockwood, Munn, and Porritt 2015: 179)

Figure 1: PRISMA 2009 Flow Diagram (Lockwood, Munn and Porritt 2015)



2.1.10 Assessing the Quality of the Studies

At first the search strategy was framed using the PRISMA flowchart, but subsequently this was used for illustrative purposes only, to present the included studies, to thereby incorporate further in-depth analysis. Identified articles were then appraised using the Critical Appraisal Skills Programme (CASP) two checklists: 1. Critical Appraisal Tool for Systematic Review (CASP 2022a) and 2. The Checklist for Qualitative Research (CASP 2022b). The first judged the broader questions of quality such as characteristics, (articulation of research questions, adequacy of strategy, methodology appropriateness and logical presentation of evidence) in an “umbrella” usage recommended by Aromataris et al. (2015). The Checklist for Qualitative Research (CASP 2022b) was then applied to synthesise the particulars of different types of evidence and their methodological quality. An example of the application of the Critical Appraisal Skills Programme (CASP 2022a) checklist is provided in Appendix 7. As a useful framework to assess validity, reliability, and applicability of studies (Long et al. 2020), this supported being systematic and consistent in how literature was reviewed. This is an important part of qualitative evidence synthesis process.

The justification for using more than one model in conjunction with the other is to foster a balanced view and narrow down the oversight to specific aspects of quality. One limitation of this, however, is potentially a less systematic approach. To address this, careful documentation of the search strategy ensured results are replicable.

2.1.11 Characteristics of the Studies

Despite being predominantly a *qualitative* evidence synthesis, still quantitative and mixed papers were included in the literature review. Certain studies (like Minerva’s (2015; 2017) work set in Italy) contain statistical evidence on conscientious objection prevalence. Moreover, availability/accessibility of abortion services is a feature particularly of the US studies cited (such as Jones and Chiu 2023).

The global context of the search strategy reiterates how many countries are undergoing regulation, or even deregulation of abortion laws (Ambast et al. 2023). In countries, like Ireland (where decriminalisation had already taken place in repeal of the eighth amendment) and Australia (where Keogh et al. 2019 detail reform of clause 8), the evidence reviewed was important to evaluate the impact of constitutional reform. In fact, Stifani et al.’s (2022) paper proved influential in shaping recommendations on accommodation of conscientious objection as an integral part of decriminalisation.

Suffice to say that international comparisons (similar to those portrayed by Aurthur et al. 2016) were important to the learning and identification of knowledge gaps. The evidence sourced therefore was not confined to any country and within WHO member states, nor any particular setting. This non-specificity represents the variety of healthcare participatory roles. Where moral reasoning may be a determinant of employment, practitioners may choose to work outside of departments where abortion takes place. I did not wish to exclude them nor restrict the insight to either objectors or non-objecting status. One aspect of the setting which arose in the data findings (and appeared as a perspective in the Model of CO Definition) was the distinction between gynaecology and maternity services. This was not so prevalent a detail in literature reviewed compared to the attention paid to the organisation of services by participants. The idea links to the distinctions between nursing and midwifery and how the participatory role is distinguished if services reconfigure (as in the case of Doogan versus Woods). Most of the early papers focused on nurses' ethical dilemmas and latterly on midwives, too, but in their extended role. None of the papers mentioned the influence of dual qualification (pertaining to RN/RM status) mentioned more in the data.

As regards demographic data, few of the studies mentioned protected specifications – only one mentioned gender as having significant bearing on ethical decision-making amongst students (Nieminen et al. 2015), and none mentioned age or culture, for example. Professional length of service and the extended role associated with experience, however, does have some mention in respect of the midwife's participation but these tend to be more recent papers (for example, Vermeulen et al. 2023 and in the works by Fleming et al. on the subject). Older perspectives on conscience and morality tend to be more dated, theological, and philosophical rather than psychological in origin. The vast amount of evidence show how ancient thinking can be traced back from Classical through Enlightenment to Modern periods of Western philosophy, yet still ancient teleological questions about the nature of life and being remain unanswered. That fact alone shows there is no definitive right and wrong. The medico-legal slant of grey literature and guidance which are constantly being updated reflects the dynamics of current sexual and reproductive health, whose parameters are constantly being extended. To this end, it was necessary to revisit the literature review at key points in the research.

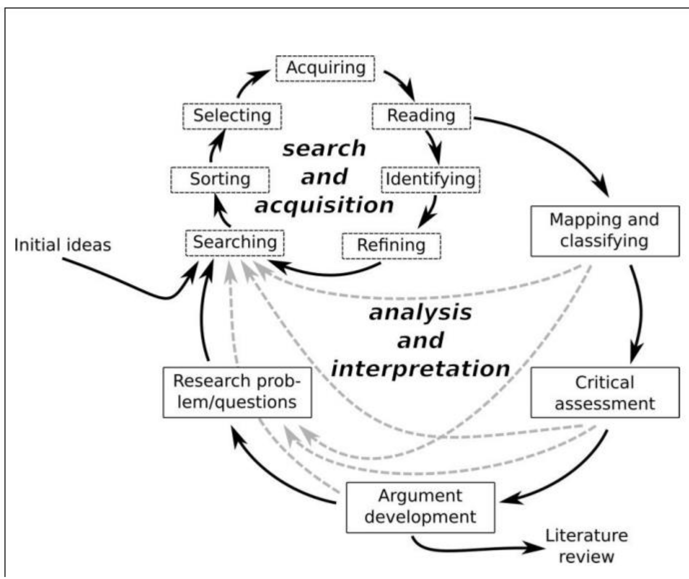
2.1.12 Revisiting the Literature Review

A literature review is usually one of the first tasks carried out. Although the data gleaned is deemed secondary, it forms part of a synthesis of knowledge as a "cumulative

endeavour" (Pare and Kitsiou 2017: 157). A priori reading combined with critical analysis can help to refine a topic, prevent repeating work, and frame research questions. In IPA tradition, however, literature is reviewed following write-up of findings and data collection. The retrospective survey of scholarly sources is what distinguishes IPA from other methodologies, say, a narrative review. The main logic of this approach is to keep true to the participant's own sense and meaning making of the phenomenon. Originality of data and its interpretation (rather than the researcher's) are what matter, in this case maintaining a fresh perspective on conscientious objection without direction, oppressive over bearing, unecessary interference or undue influence (Blundell et al. 2022).

According to strict phenomenological protocols, the decision to revisit the literature review was thus a controversial one, which did nevertheless serve a purpose: to update the citations and maintain a contemporaneous 'qualitative evidence synthesis'. The hybrid technique employed brought the best of both review approaches. The addition of phraseology 'IPA' + 'lived experience' did yield a number of additional papers, but despite the time interval, this study remained the only IPA-based study of its kind into conscientious objection from midwives' perspectives. In reconducting a similar search strategy, one important paper came to light. Latterly, the work of Boell et al. (2014) provided insight into a 'Hermeneutic Approach to Conducting Literature Reviews and Literature Searches' – as an interaction with theory.

Figure 2: A Hermeneutic Circle Showing the Literature Review Process (Boell et al. (2014: 264)



Although the replicability of the search strategy is a desirable feature of the “quality and success of scholarly activity” Boell et al. (2014: 257), it is true, the originality of this two tier strategy achieved a certain IPA-ness. Iterative interpretation, developing understanding and making sense of knowledge were part of the Hermeneutic circle (see figure 2). A fusion of horizons occurred both pre and post-data collection. So much changed in the conscientious objection field in the course of the PhD study. Rather than a singular Heideggerian snapshot in time and space, it was interesting to have this renaissance through the dual strategies employed.

2.1.13 Search Strategy Conclusion

It has been shown how the integrative approach of the search strategy helped arrive at a selection from the literature for critical appraisal. According to the overarching literature review aim, (which more specifically encompassed several secondary review questions) using keywords and inclusion/exclusion criteria formed the main part of the strategy by which a number of papers were identified. Those papers’ quality was assessed using the frameworks of two key works – The Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) and the Critical Appraisal Skills Programme (CASP). The characteristics of the qualitative evidence synthesis have been described, demonstrating a hybrid process, in which the literature review was revisited at key points in the research, in keeping with Hermeneutic principles. The rationale and controversies of adapting phenomenological protocols have been discussed.

Now, the thesis will establish what information was gleaned from the papers and where the body of knowledge currently stands theoretically.

2.2 A Closer Look at What Conscientious Objection Comprises

Modern cases appearing before the courts more often relate to section 4 (1) of the 1967 Abortion Act – the so-called “conscience clause”. This legislatively made allowances for practitioners’ rights to decline involvement, a phenomenon known as “conscientious objection” (CO). That appearance of CO-related cases in the Courts at all shows how provision made in the 1967 Act is not wholly effective to resolve employment disputes for contemporary midwives’ within the context of their multi-disciplinary healthcare teams. Although the language of refusal is argued to be better thought of as objection than refusal (Jones-Nosacek 2021: 242), Odell et al. (2014: 1) state,

"Conscientious objection refers to a person's refusal to engage a service that violates his or her deeply held beliefs about right and wrong."

The meeting of private and public spheres is a theme adopted in the literature reviewed (Wicclair 2011). "Core beliefs" (Byrnes 2021: 291) like these are "personally held and privately known". It is this characteristic which makes CO so incongruent with a healthcare role within communities, affecting others. Guillen and Capitulo (2009: 5) define conscientious objection as,

"The refusal to comply with professional obligations as stated by law or institutional rule, doing so by claiming moral or conscientious reasons… (It is) a collision of rights and a conflict of values".

Whilst definitions of conscientious objection may vary, they basically say similar things: incompatible beliefs can sometimes bring employees into conflict with employers (and employment practices can sometimes bring employees into conflict with themselves). The definitive version is arguably forwarded by Wicclair (2011: 1), which highlights how idiographic and essentially individualistic dilemmas may be. In all three of these definitions, there is an element of exercising value judgments and making moral decisions. This thesis will focus on how these are elucidated in what has been shown to be highly reflective and circumspect practice by drawing on ethical theory. Research questions relating to midwives' understanding of these definitions will highlight inherent difficulties associated with assumptions. What comprises the midwife's role and what are their professional obligations are definitions widely called for (Oderberg 2018). 'Refusal to comply' maybe interpreted as notoriously problematic, because objection may range from partial to extreme (Fink et al. 2016). CO does not always equate with an out and out refusal, per se. Sometimes, an acceptance of different aspects of participation can be accommodated. Whilst using formulaic definitions like this may help conceptualisation, freedom of conscience in practice means different things to different people. In fact, CO behaviours manifest in varied ways, research shows (Lamb 2016), mostly depending on perceptions of what constitutes the beginning of life and what is morally right. These represent epic decisions for some midwives used to nurturing pregnancies, what happens when the pregnant person needs it to end?

2.3 Causes of Conscientious Objection

Whilst some researchers argue the motivation for conscientious objection is largely religious (Weinstock 2014; Toro-Flores 2017), complex moral reasons remain why

people conscientiously object (See Appendix 9, Fleming et al. 2018). In fact, sometimes the two justifications are interlaced (See Appendix 8). Wicclair (2011) stresses the nature of conscience-based refusals, which he suggests are equally value-laden, though non-affiliated to a single doctrine. Beliefs around when life starts, fetus' personhood, the status or rights of the fetus, attitudes to disability, personal experiences (both professional and personal) may all have a bearing on how midwives rationalise their contribution or their moral complicity, a concept which will be subsequently examined. Different pregnancy related factors may feature, too: gestation, parity, previous medical and gynaecological history and the presence or absence of a life-limiting condition may influence midwives' decisions. Woman-centred reasons such as demographics and her justification may make the objection harder, for example.

Critics such as Savulescu, Giubilini, Schuklenk, Smalling and others would argue that the reasons don't (or ought not to) matter; that the healthcare professional (HCP) is not there to judge, and the abortion-seeking decisions are tough enough without encountering discrimination or being called to account. Thus, some would argue that the decision and its emotional or conscience-related consequences are born by the woman, less by the midwife. Bound up with assumptions, often ingrained pre-understandings, these influences are complex to the extent that critics say flexibility is impossible, that no CO system is responsive enough to act as a barometer on the woman's needs, also highly complex.

2.4 Appearances of CO: Fink et al.'s (2016) Spectrum of CO

Fink et al.'s (2016) study revealed views which were categorised in tri-partite manner ranging across a spectrum:

a) **Partial:** participants performed some abortions, but refused to do others on the basis largely of gestational age or case–by–case circumstances;

b) **Moderate:** participants would not perform abortion but respected their patients and viewed termination of pregnancy as necessary 'to save one of two lives';

c) **Extreme:** participants refused entirely to take part in abortion *and* make referrals. Extremists often lectured their patients, providing misleading and sometimes false information. On occasion, preventing women accessing the abortion services that they are entitled to occurred.

Although only small scale and country-specific, making it hard to generalise, this study's main contribution in terms of identifying the panorama of freedom of conscience. Fink et al.'s work is used as a starting point because it brings some order to the range of

diverse arguments presented by medical conscientious objectors, on which basis decisions are determined. Fink's work is key in understanding operationalisation of the process, breaking down how abortion is rationalised at key points in the abortion journey. Areas for future research were pinpointed, moreover, where further clarification is needed. For example, identification of factors which prompt CO, what form it may take and estimates of its prevalence.

The circumstances that outrage some of the public concerned over freedom of conscience decisions, abortion permissibility and inconsistencies will be covered. How these ethical decisions are morally reasoned amongst professionals will be the focus of this thesis. Fink et al. suggest potential interventions that could reduce the role of the conscientious objector as a barrier to care. Progress against this impasse will be this study's most important endeavour – to enhance access reasonable and regulated, equitable and ethical, legal and endorsed conscience systems that can better accommodate the vested interests of *all* parties concerned. It is not argued that abortion service-users in crisis receive care, which is sub-standard, or negated in anyway by objection.

Giubilini and Savulescu (2020) provide an example to illustrate the comparable experiences of two service-users which highlight these inconsistencies in access (See Figure 3 below). Whilst this example highlights that professionals do experience dilemmas, the decision-making process that leads each of the practitioners to a very different conclusion is less clear. The deliberation on how each rationalises providing a consistent and universal service for service-users whose needs may be very disparate is vague. This study fills in those knowledge gaps.

Figure 3: One Example (Giubilini and Savulescu 2020: 230)

Jane and Joanna are pregnant and due to serious medical complications, both need an abortion, which is legal in the country where they live. Joanna is in a hospital and the doctor who is in charge of her care is a committed Catholic. Religious opposition to abortion among physicians is very widespread and typically protected by the law in the form of various 'CO' policies. Jane is in the same situation as Joanna, but her doctor is a feminist, and she strongly believes that, quite apart from their professional obligations, women have an absolute moral right to decide whether to terminate a pregnancy. Thus, both doctors have personal religious or moral views that give them reasons and motivations to act in certain ways and that might affect their professional practice. After consultation, Joanna's doctor refuses to provide the abortion and Jane's doctor offers the service.

The cases demonstrate that personal belief and professional personae sometimes do overlap. In an often politicised and polarised debate, accusations of a lack of Humanitarianism abound. Each of the professionals in the example think they are morally right and feels justified in their decision-making. The case upholds the duty to refer and reiterates the detrimental effect of care because of CO. The aim of this study is to contribute to greater understanding of the lived experience of ethical dilemmas and gain an appreciation of the internal mechanisms which professionals encounter, like those cited. This thesis maintains that although the doctor's participation in procedures may be different to midwives', the need to recognise and accommodate mutual and universal rights of freedom of conscience is wholly supported. This premise is regardless of the different 'part in participation' played out between doctors and midwives, whose ethical dimension is poorly understood.

Canada is the only country in the world where abortion is free of legal restrictions and designated as a medical service. Canada's longstanding view is that fetuses do not have personhood status, but here too 'conscience-related issues' are being scrutinised. (Lindeman 2023). Lamb at al. (2019) similarly opted for a study design using phenomenological, interpretative research methodology to examine the lived experience of CO for registered nurses in Ontario. In their study, six key themes appeared in data analysis: Encountering the problem; Knowing oneself; Taking a stand; Alone and uncertain; Caring for others; Perceptions of support. This is useful since open dialogue

provides both a singular and pluralistic view of freedom of conscience, which will later be examined in the role of institutions. For Lamb (2019: 1321),

“Conscience emerged as an informant to nurses’ conscientious objection”.

One contrast that appears is that of implicit versus explicit that is informal or formally expressed in this very much nurse–centred research. Whilst few studies mention the role of midwives, in terms of reasoning related to abortion participation, the challenge of this study is to appreciate the mechanisms in which conscience impacts on decisions affecting Maternity care. It’s strength is in recognising midwives’ perspectives.

Three domains feature in the research of Harris et al. (2016) which similarly show emergent CO links between ethos and its manifestation: beliefs about abortion and CO; actions related to abortion and CO; self–identification as a conscientious objector. Unlike their compact, yet comprehensive categories suggest, freedom of conscience issues are arguably rather more complex and poorly understood. Generally, Harris at al. suggest that policies and even debates around the world do not consider the social, economic, and political pressures profoundly influencing clinicians. Using examples of stigma associated with abortion and indeed CO, they state,

“CO can become a safety valve for clinicians.” (Harris et al. 2016: 6)

2.5 Support for the Legal Right to Conscientiously Object

Support for the international legal right to CO is provided for in Article 9 of the European Convention on Human Rights (Council of Europe 1950). This relates to freedom of conscience, thought and expression and came into UK law with the Human Rights Act (1998). In a medical context, however, the law’s application is constantly being challenged in varied ways across the globe (Chavkin et al. 2017; Fleming and Robb 2019; Regan and Glasier 2017; Will 2013a; 2013b). In practice, the legal premise of CO has been interpreted for different gestations (Gomez-Lobo 2004; Marquis 2001; 2002), in different cases at different times by different providers (Campbell 2011; Chavkin et al. 2017; Erdman 2017; Fleming et al. 2019). Understanding of the law is wholly incomplete, poorly covering the representational rights of employees in a changing workplace.

The Scottish case of two midwives who took their employers, Greater Glasgow and Clyde Health Board (GGCHB), to court highlights these dilemmas (Harmon 2016). Ultimately the Supreme Court ruled in favour of the employer, calling for closer definition

of the term “participation”, what comprises actions that actually contribute to fetal demise (Fleming and Robb 2019). Although the Bill aimed to “give shelter from compulsion” (Oderberg 2018), it failed largely because of the language of ‘participation’, suggests Oderberg, which should be substituted by terminology such as ‘performance’, ‘assistance’ or ‘co-operation’ to reassure the uninitiated.

The extended role of advanced practitioners and the changing nature of abortion procedures (from surgical to medical) have brought new challenges for multi-disciplinary team working (Wicclair 2011; Ramsayer and Fleming 2020). The Act, which aimed to address medics, does not set out specific reference to other professionals. Closer examination of these issues amongst midwives will be the focus of the study.

In a globalised arena and pluralist society, there is limited acknowledgement of the cultural implications of CO. Although CO is not included in legislation in some countries, rates are high in others. In Italy, where Roman Catholicism (RC) is the predominant religion, CO is estimated to be as high as 70% (Minerva 2015) whilst in the UK, CO is suggested to be increasing (Dobrowolska et al. 2020). Supervision has been recognised by the RCOG (2011), how to better support freedom of conscience decision–making to standardise such local/regional/national/international differences.

CO in an age of telemedicine, brought about by the COVID 19 pandemic, has led to even more controversy and ethical dilemmas (Neal 2017) described as “an eclectic mix of regressive, neutral and progressive policies”, by Romanis et al. (2020: 479).

2.6 Is Conscientious Objection Reasonable for Service-Users?

Lamb et al. (2019: 1337) show freedom of conscience for service-users is exacerbated in two main areas:

1. By delaying/blocking access to existing services
2. By contributing to the actual lack of providers and services

They recognise a need for morally inclusive environments, noting the setting in which freedom of conscience decisions are made appears to make a difference. Authors explore options for achieving improved accommodation in a wholesale call for action to better understand rights in practice.

In Victoria, Australia, where reform of ‘clause 8’ of the abortion law is being enacted, Keogh et al. (2019) conducted nineteen interviews with expert doctors, which were

thematically analysed. The current situation, they maintain “unfairly impacts on women", (Keogh et al. 2019: 1) drawing attention, for example, to the use (or misuse) of CO by government telephone staff, pharmacists, institutions, and political groups. Categories centred more on the wider picture of health and medical practice in terms of: the purpose of clause 8; perception as a mechanism to ensure women's rights; perception as a mechanism to ensure doctors’ rights; implementation of medical practice; direct contravening of law required to refer; doctors attempting to delay women’s access; doctors attempting to make women feel guilty; doctors objecting from any other reason than conscience; the use of CO by groups and individuals other than doctors.

Boama (2018) takes a rather more practical approach to effects of CO in the workplace on colleagues. He suggests work overload, associated with allocation to abortion duties, places excessive and undue demands on ‘the abortion doctor’ which exacerbates a sense of abandonment, stigma, stress, and burnout. An anecdotal look at abortion services, his work can be criticised for being medic-centric, but he does provide useful insight into international comparisons between low- and middle-income indexed countries, though small in study design. Lessons learned, particularly surrounding successful implementation strategies and barriers to avoiding maternal mortalities serve as ‘stepping-stones’ in a wider context.

In cases of objection , there is a recognised potential for unregulated CO to do harm. The practitioner who carries out procedures may well view the detrimental effect of continuing the unwanted pregnancy whereas the conscientious objector may view their actions as wholly beneficent. Their professional judgment, of course, is not to be used as a cover–up for imposing personal values, however, which amounts to disrespecting persons disregarding autonomy.

Savulescu (2006: 294) thinks CO is “wrong and immoral”, with such paternalism having “little place in the delivery of modern healthcare.” Just distribution of finite resources is defined by law, he suggests. Partial discharge of a professionals’ duty to care for patients is an unfair infliction of their own values, open to abuse and misdemeanour. The power of the professional, which has crept into clinical decision-making, pits one against the other in a power struggle, where odds are stacked. Inefficiency, inequity and inconsistency lead to the scenario in which patients must “shop for professionals”, inevitably less informed about their entitlements and treated less favourably. Risks of legal uncertainties, suggests Savulescu, mean that patients have fewer alternatives, prompting theorists to search for a solution to enigmatic dilemmas and render more compatible entrenched positions.

2.7 The Approach to CO by Wicclair (2011)

Three main approaches to solving these problems are highlighted by Wicclair (2011):

"**Incompatibility**" which holds it is contrary to the professional obligations of health care practitioners to refuse provision of any service within the scope of their professional competence.

"**Conscience Absolutism**" which holds that health care practitioners should be exempted from performing any action contrary to their conscience.

"**Accommodation**" A compromise approach that accommodates conscience-based refusals within the limits of specified ethical constraints.

The main position adopted for the present study is that, like Wicclair, moral integrity is worth defending, but with limits. This standpoint is not without criticism. Some commentators for example, (Savulescu and Giubilini 2018; Shahvisi 2018) argue that inefficiencies and inequalities in access to the care patients receive are too high a price to pay for CO accommodation. Restricting access to legally permitted, beneficial care for the patient is not part of a HCP's legitimate role, simply because of a conflict of values. For critics, this compromise of patient welfare, is too weighty to bear, leaving the vulnerable like consumers, shopping for essential services. Fiala and Arthur (2014: 1) agree that refusals to treat should be viewed as "dishonourable disobedience", which may require statutory intervention to redress imbalances, particularly at institutional level.

2.8 Literature Review by Themes

2.8.1 Theme 1 - Practising Midwife, Practising Religion

Weinstock (2014) in his work on whether religion makes a difference to CO, concluded that the justification of conscientious objection in objectors' moral 'vocabulary' should be considered as separate and distinct concepts: freedom of conscience and freedom of religion. These are classified as either an *internal* right to accommodation (protecting the agent's ability to critically reflect on moral and political issues that arise professionally or in society generally) or an *external* irreducibly religious exemption (securing membership of a set of practices and rituals that have a moral narrative). To this end, religion and conscience will be examined as a justification for objection n turn, impacting on moral reasoning, under a broader, non-denominational heading of a faith-based and ideological look at CO.

2.8.2 A Faith-Based and Ideological Look at CO

According to Katz (2015), the first ever conscientious objector was in the Old Testament, Saul, first King of Israel. Jews were considered at the time to be 'God's chosen people', reaffirming the sanctity of life was a rite, a demonstration of faith. Saad (2019) notes the reappearance of CO during the Eighteenth century when the term "impartial spectator" was coined, first by Adam Smith. Historically, most of the literature cites the position of the UK government and CO in relation to military service, first recognised in 1787.

The first legal definition appeared in 1916. During the two World Wars, the UK government accommodated 76,000 conscientious objectors. More recently, protection of health care workers featured in discussions around three areas: euthanasia by withdrawal of life-sustaining treatment; artificial reproduction under the Human fertilisation and Embryology Act; and abortion for the Conscientious Objection (Medical Activities) Bill (2018). In debating the issue, Rt Hon. Fiona Bruce suggests there are many reasons why people may genuinely conscientiously object – in employment, through family needs, disability or on religious or moral grounds. A blog response reminds the reader about the first documented *medical* objectors: 68,000 medics' unwilling to participate in enacting the 1943 Nazi Memorandum which singled out subversive doctors who protested against the Third Reich and their ideological plans for the Final Solution. To this end, Bruce (2018: 2) says,

"Accommodation of CO is a long-respected matter of liberty and equality in this country. This respect should be as relevant today as ever."

The inclusion of CO in the 2010 Equality Act, which provided for freedom of belief, is characteristic of the public debate centring on religious observance. It is against this background that freedom of conscience is under scrutiny. Tolerance in British society today, of course, and civil liberties are not solely for Christians or for the religious. To this end, Rt. Hon Bruce (2018) citing examples of Baroness' O'Loan's fore-running work, in the parliamentary magazine "The House" Bruce stresses,

"To suggest that conscience is only applicable with religious beliefs would be a grossly restrictive understanding of the concept."

Nonetheless, in one study on the opinion of nurses on CO (Toro-Flores et al. 2017), only 55.1 % of the 421 nurse respondents expressed a doctrine and confirmed in the research that they were religious believers (though which faith is not stated). Of respondents, those with a faith were more likely to conscientiously object. And to this end, our discussion will begin with a faith or religious examination of conscientious objection before looking at broader ideological aspects.

Let us now look at each of the major religions in turn to see how doctrines from the various denominations may impact on moral reasoning, a mostly rules-based perspective on decision-making and its deontological influences.

2.8.3 Roman Catholicism

The position of the Roman Catholic (RC) church opposes all forms of abortion procedures whose purpose is to destroy the zygote, blastocyst, embryo, or fetus. Early church legislation in the first century A.D. was based on the Apocalypse of Peter and Epistle of Barnabas (Exodus 21: 22-23), which makes the distinction between 'formed' and 'unformed life'. This does not find voice in the current doctrine of the Catholic Church, expressed in the Catechism,

"Human life must be respected, protected absolutely from the moment of conception. From the moment of its existence, a human must be recognised as having rights of a person among which is the inviolable right of every innocent to life."

Belief about the RC stance centres on understanding of the moment an embryo gains a human soul. In addressing timing and the age of viability, early theologian authors believed that "quickening" (the rapid fluttering movements made by the unborn fetus) was the point of "ensoulment" occurs: in Latin, "tam quam", "as if" a human person. Viewed as a sin, but not murder, with judicial consequences, RCs can be absolved of sin if certain conditions are met, that abortion is deemed a morally legitimate act which indirectly results in the death of a fetus, for example, removal of a cancerous uterus (BBC 2019).

2.8.4 The Church of England (C of E)

The General Synod has passed a resolution which clearly sets out the coherent position of the C of E:

“The C of E combines strong opposition to abortion with a recognition that there can be strictly limited conditions under which abortion may be morally preferable to any available alternative.”

Although the C of E Board of Social Responsibility (1980) does recognise,

“The fetus has a right to live and develop as a member of the human family.”

The General Synod in 1983 agreed that in situations where the continuation of a pregnancy threatens the life of a mother, abortion can be “justified” (BBC 2019).

2.8.5 Hinduism

In Veridic tradition, abortion is deemed morally wrong. The Veridic text compares abortion to the killing of one’s parents or a priest. The correct value system of Hinduism teaches that the correct course of action in any situation is the one that establishes least harm to those involved. In the case of abortion, therefore, termination of pregnancy is considered acceptable only if the mother’s life is at risk – respecting beneficence (BBC 2019). In a staunchly traditional view, termination of pregnancy is seen to deprive society of another member of the family and the community, so abortion is seen as a breach of duty – ethically contra-indicting the utility principle. The cultural preference for sons, of course, and the correction of “the soul and the matter” in the doctrine of reincarnation, means that the developing fetus has entirely no sense of personhood. In British law, a similar principle is enshrined – that the fetus has no legal rights of its own, only superseded by that of the mother.

Spiritually, in Hinduism, only a reborn soul can achieve substantial awareness. The spiritual aim is to break free of this with a repeating life and death and rebirth cycle, as an arrested soul suffers karmic setback (deprived of an opportunity to exist or any possibility to include a deprivation of the fetus), rights not necessarily in alignment with the mother’s rights to autonomy. Ahimsa – the principle of non-violence practised by Gandhi could also be extended to a non-maleficent view of “killing embryos” especially if in some eyes if that “person is a non-aggressor”. Believing all life is sacred, loved and to be revered, as protecting manifestations of the Supreme being, conscientious objection could be seen in Hinduism as a beneficent act. In urging self – control and overcoming anger, the Bhagavad Gita adopts a Pacifist, non – violent, non – maleficent point of view.

In the Upanishads, Jainism preaches vows against the use of force and “compassion, patience and forbearance” (Duffey 2008) is an integral part of that. Drawing on the teachings

of Gandhi, we can think back to his refusal to support the British in World War II on the grounds that colonialism was inherently unjust. His CO, maintained as a means of overcoming what he saw as injustice, relied on beneficence and non-maleficence. A similar sense of fairness is invoked when we balance not only the Hindi view of the rights and wrongs of abortion, but thereby those of CO. It is noteworthy that in India, the largest Hindu state in the world, female infanticide is still practised, though predominantly unsafe and illegal. The Indian government therefore has no laws permitting conscientious objection. Unlike synods and General Councils, Hinduism has no central authority (Duffey 2008). Aspects of the transmigration of the soul and embryo disposal spiritually should be considered since in mourning rituals, last offices should not be touched by non-Hindus, which is where hospitals may cause distress, states Rutty (2016),

“Very importantly, like many other religions, Hinduism is not just a religion, but also a way of life, incorporating countless sects and practices”.

With implications for healthcare practice, therefore, and the lives of millions of people affected by abortion in India’s one billion Hindus, an international, cross-cultural solution to freedom of conscience questions is needed. Hindu’s Monotheism makes this difficult, but a workable solution is hereby urged.

2.8.6 Islam

According to Serour (2013), the ethical issues in human reproduction from an Islamic perspective, consider Islamic teaching on the sanctity of life. “Islam is strongly pro-family” and regards children as “a Gift from God” (BBC 2019). This is taken literally to mean that abortion is harmful and wrong. The only acceptable reason is given to be the woman’s life is in jeopardy. Whilst the BBC (2019) states that the Qur’an does not refer explicitly to abortion, birth control has formed part of Islamic medicine for centuries. Most Muslims, nevertheless, would maintain that the fetus is a human life and abortion forbidden after soul (or “ruh”) is given to it. The Qur’an (5:32) states,

“Whosoever has spared the life of a soul it is as though he has spared the life of all people. Whosoever has killed a soul, it is as though he has murdered all of mankind.”

In Islam, bioethics are influenced by Sharia law and the continuation of pregnancy facilitated by CO surely promotes this, observers could question.

In Sharia law, “the lesser of two evils” (BBC 2019) however, is committed if abortion is performed to save a mother’s life. But if abortion is undertaken for fear of poverty, then “trust Allah (peace be upon him) to look after things” (BBC 2019).

Ibrahim’s (2008) PhD thesis “The Moral and Legal Status of the Fetus – a Critical Analysis from an Islamic Perspective” looked to better apply Sharia law and meet the new challenges of reproductive technologies. He argues that the legal personality and the moral personality as well as the humanity of the fetus are linked in Islamic tradition. For example, from the twentieth week, as a moral agent in its own right, the fetus attains actualisation through ensoulment (Khitamy 2013). Passive potentiality only exists before then which Ibrahim maintains reconciles Sharia law to the demands of modern medicine. The fetus being in the form of property is a second embodiment which has capacity for acquiring rights and obligations (Dhimmah) under Sharia law.

2.8.7 Judaism

Given that interpretation of Hebrew scriptures depends on the belief that the words come from “the Divine mouth”, as Kaplan (2019) suggests, ancient Jewish and Christian refusal to “take up the sword” powerfully finds voice in the CO movement.

“Jewish law does not share the belief … that life begins at conception, the fetus attains the stature of a full person only at birth”, states Shurpin (2019).

He goes on to state that the Talmud indicates that prior to 40 weeks gestation, the fetus accrues limited legal status as “mere water” (Yevamot 69b). Genesis 9.6 prohibits “shedding blood of man within man”, a quote which is attributed to the source of the religious prohibition of abortion, but which may also be seen as a gender issue, perhaps. Judaism teaches that the body is ultimately the property of God and merely on loan to humankind (which could be seen contrary to the idea of personhood). Whilst “neither condoning it no categorically prohibiting abortion” according to Shurpin (2019) in some circumstances, Judaism does allow abortion. Rabbis on both sides have been “vocal in the support of keeping abortion legal and accessible”.

In Israel, abortion remains illegal and women wishing to undergo abortion must appear before a three – person Committee. Subsidised by the state, for women between 20-30 years of age, half the number of abortions is performed in private clinics.

Whether religiously motivated or not, these ideologies all are closely associated with the concept of conscience. We will now turn to non-denominational moral reasoning and dilemmas inspired by conscience.

2.8.8 What is Conscience and How Is It Different to Moral Reasoning?

The literature on conscience in medicine has paid little attention to what is meant traditionally by the word 'conscience', suggests Sulmasy (2008). This gap in the knowledge is where IPA has much to offer in terms of understanding the psychological processes and what happens unique to midwives' lived experience,

"When a person consults his conscience...he examines his moral convictions to determine what he really thinks and feels," says Childress (1979: 319).

Sulmasy (2008) gives us an insight into the concept's complexities. He distinguishes between retrospective (also known as 'judicial' conscience, when we decide to do something which on further reflection is deemed wrong) and 'prospective' conscience (sometimes known as 'legislative' conscience, most of concern to medics, which relates to something we anticipate doing). He further describes the process of 'synderesis' (moral decision-making and discursive reasoning). This Medieval premise, which originated in thinkers like Thomas Aquinas, refers to an innate habit 'in the sense that a person who reflects upon his nature will see that certain things are good for him, and certain things are bad for him.'' It is distinguished from 'conscientia' (conscience) which dictates if an action is right or wrong. The difference is significant to CO, here because of its qualities of self-reflection. Sulmasy argues against an 'intuition-orientated' view of conscience because it is fallible. There is no such thing as a "distinct mental faculty…a little voice whispering to us" to determine between right from wrong without advice or consultation (Sulmasy 2008: 136). Sulmasy (2008: 135) states,

"Conscience is defined as having two interrelated parts: (1) a commitment to morality itself; to acting and choosing morally according to the best of one's ability, and (2) the activity of judging that an act one has done, or about which one is deliberating would violate that commitment. Tolerance is defined as mutual respect for conscience."

Sulmasy later clarifies what he means in his definition of 'conscience' as,

"A commitment to morality, to having moral precepts and acting in accordance with them" (Sulmasy 2019: 507).

Arguably, Wicclair (2011: 1-5) most expansively addresses Sulmasy's gaps in his (2008) definition. Wicclair traces back to Butler's (1827) 'internal principles of his heart'. This focused on a more epistemological interpretation of religious function then onto more modern conceptions, beyond an internalised set of social norms.

Contextually, Wicclair's theory builds on what can and cannot be considered appeals to conscience by different healthcare professions. This thesis is based on his model.

As an introspective self-judgment on the moral goodness or blameworthiness of one's own conduct, intentions, or character, conscience aligns with morality in its feeling of obligation to do right or be good. Whereas morality is more societally informed, however, conscience is self-imposed. Arguably subjective and infinitely variable, conscience centres around the individual – their values, reasoning, and internalising mechanisms. Although conscience may be ethically driven, in that it could be said to be motivated by beneficence and non-maleficence, autonomy, justice and fairness, there are no rules to conscience, no set of principles, no schools of thought.

To this end, Giubilini (2021) defines conscience,

"By its inward looking and subjective character, in the following sense: conscience is always knowledge of ourselves, or awareness of moral principles we have committed to, or assessment of ourselves, or motivation to act that comes from within us (as opposed to external impositions)."

2.8.9 The Relevance of Conscience to Healthcare

"The role of conscience in medicine goes to the heart of what it means to act in a moral way … with integrity,"

writes Emeritus Professor Wyatt, of the Neonatal Paediatrics Group All Party Parliamentary Profile Enquiry (cited in Bruce (2018). Integrity is often used in health care and in this case, is taken to mean "morally intact" or "functional". Moral questions, Professor Wyatt suggests are a matter of "internal health" (Bruce 2018). How healthy, therefore, can a health system be that disregard, or does not address accommodation as a solution to these moral questions? Drawing on the sense of "moral duty" that is often the motivation for joining and staying in the caring professions, Rt Hon Bruce (2018) poses the questions,

“What kind of criticism is it to suggest that healthcare professionals should be obliged to ignore their moral compass? To exercise their skills merely as functionaries of the state – particularly in matters of life and death?”

The expectation of society to ignore deep reservations and carry on regardless is very simplistic, akin to implying healthcare workers should act like machines. But we are dealing with a social science and humanity – with flesh and bones, blood, minds, hearts, and souls and all that those are perceived to be. Conscience exists to protect patients as well as the professionals caring for them, who after all, possess parallel moral needs - in common humanity. Savulescu (2001: 295) looked at the dangers of using conscience–less eugenics and commented,

“Conscience can be an excuse for vice or invoked to avoid doing one’s duty…. the door to value-driven medicine is a door to a Pandora’s box of idiosyncratic, bigoted values and discrimination.”

Furthermore, Giubilini (2014) suggests that far from promoting ethical principles of equity in care, CO could be in a healthcare context abused by arising from racism, prejudice, sexism, preferences, and power imbalances. Indeed, the law protects the individual against discrimination on either opposing side of the freedom of conscience divide.

Brock (2008) likewise argues that moral integrity is at the heart of all ethical decision-making in relation to CO. These should be respected because so deeply held convictions and commitments are central to personal identity. Brock calls for “conventional compromise” a moderation of entrenched views (which in Brock’s opinion presents mostly in general practice and public sector hospital workers). His work is pertinent to our discussion here because many of the arguments are presented along a similar trajectory or spectrum.

Birchley commented (2012: 13) conscientiousness presents as a form of becoming empowered,

“A pang of conscience may be useful in rapidly unfolding situations in which there is no time to reflect satisfactorily upon activities and that, given the hierarchical nature of healthcare institutions, a right to defy authority on the basis of conscience may benefit junior staff who lack the institutional power to challenge the orders of superiors.”

Despite painting a chaotic, clinical picture, his metaphor is useful to highlight the importance of conscience to professionals (and indeed to their patients and the community served). Indeed, history testifies to this too. The headlines are splattered with cases, as far back as Mengele, where standards of professional behaviour have slipped, oaths have been broken, codes not followed, and injury ensues.

Although more precisely concerned with the context of Adolf Eichmann's Nuremberg trials after the Nazi atrocities of World War II, Hannah Arendt makes poignant reference to conscience (described by Vetlesen, 2001: **8**). Arendt, whose doctoral thesis on Saint Augustine, takes a theological view, determined that understanding Nazi evil was no "value-free or normatively neutral task", according to Vetlesen (2001: **7**). Drawing on Socrates' teachings (who argued no-one could do evil voluntarily), Arendt (1929: **84**) attributes conscience to the presence of God and our reliance on God,

"Conscience is 'of God' and has the function of pointing to the creator rather than the creature."

Whilst some view conscience (and its related concept of 'consciousness') as a valuable attribute to nurture, others question if reliance on the nature of individuals and the subjective judgments they make is a weakness in conscience systems, fraught with inconsistencies.

Of course, conscience is not a substitute for criminal/civil law, the judicial system and regulation of practice or policy guidance. By the patient's bedside, however, conscience is the final check and gauge against hands-on harm. Is this a leap of faith for society which places undue burdens on individual practitioners and assumes all morality is homogenous? Hannah Arendt thinks not. Her work vocalises why conscience matters in conscience matters. On the relationship between thoughtlessness and evil, she invoked conscience and remarks,

"The sad truth is that most evil is done by people who never make up their minds to be good or evil." (Arendt 1978: 162)

Although the focus is on medical CO, Clarke's (2016) military analogy helps us understand how objectors sometimes are treated for acting out according to their self-defined and interpreted moral principles. In considering the role of tribunals in determining alternative forms of service for conscripted soldiers, Clarke (2017) makes a

distinction between the two, based on 'causal contribution to a class of acts found to be objectionable'. Clarke (2017: 219) notes,

"A doctor who conscientiously refuses to conduct an abortion, but who is happy to go on working for an organisation in which other doctors conduct abortions, is analogous to a conscript who refuses to kill but is willing to serve the military in non-combat roles."

Whilst Wicclair (2011) points that CO is a term more associated with the armed forces, he is keen to distinguish between CO in healthcare (or 'conscience-based refusals', as he calls them) and violations of law in civil disobedience. The aim of the latter is to bring about social change by proactivity, rather than forgoing action or an omission. Wicclair (2011: 223) calls this his 'moral asymmetry' thesis: with 'negative duties' not to harm (N-duties) as opposed to 'positive duties' (P- duties) which positively appeal to conscience.

The point remains however, that the conscience part of CO is personal and self-regulating, weighted by one's own inner voice, regardless of what others may say about it. Whilst tribunals may have a role in holding people to account in a forum, conscience calls on one to justify one's reasons only to oneself. The punitive and potentially damning component of tribunals means the verdict is out on their usefulness. Suffice to say as far as conscience goes, decision-making is about self-discipline rather than being disciplined.

2.8.10 Conscience in the Main Abortion Arguments

A model has been drawn upon in the following overview including Tooley et al. (2009: **ii**) whose widely cited book entitled 'Three Perspectives', is viewed as a seminal text on the current issues.

Table 1: Three Perspectives (Tooley et al. 2009)

"liberal" pro-choice approach	**"communitarian" pro-life approach**	**"gender justice" approach**
Autonomy principles dictate the woman's body belongs to her and she can control what happens to her fetus.	The fetus is a person and can feel pain. Killing is depriving the fetus of life.	The fetus is not a person yet and has no sentience, moral reasoning and is not capable of sustaining independent life.

Prevention is better than cure – contraception should be readily available – which gives control and protects the woman against harassment and manipulation.	An innocent life needs protection and has potential to make a valued contribution to society, living a full, happy life. Contraception distorts nature and God's will.	Banning abortion puts women at risk by forcing them to use illegal abortionists.
The woman's role is central to abortion decision-making- she is capable of independent thought about the choices best for her.	Society and the State decide what is in the interests of the greatest happiness of the greatest number.	'Hands of my uterus' – the woman's needs are paramount; abortion brings with it gender equality.

Making triangular, the so far two-sided debate, we can draw on this model for CO because if midwives are to morally reason, it affords us insight into how and on what basis they ground their decisions to conscientiously object to partaking in abortion. Let us look closer at an opponent's view. Beckwith (2010) critiques Tooley's 'liberal' section of the model (which maintains that the pro-life case relies on its proponents' belief that the unborn possesses an immaterial soul and that any non-materialist view of the human being could not possibly withstand the scrutiny of "science"). Tooley concludes that some form of mind-body physicalism is the right view, but Beckwith says Tooley does so without even introducing the reader to the many sophisticated philosophical components, remembering, that moral and legal permissibility are separate entities.

Gensler (1986: 86) also puts forth a critique of Tooley's pro-life recognition of humans' as ''rational animals connecting with desires conceptually",

"The human fetus, while it might develop into a being with a right to life, presently has no more right to life than a mouse fetus."

The "trouble", with Tooley's position, Gensler (1986: 87) suggests, is its portrayal of "intuitions; so, the argument cannot decide the main issue." This reminds us of Sulmasy's warning about using intuition in morality because it is so fallible.

The Kantian argument against abortion expounded by Gensler (1986), conversely emphasises the importance of consistency, logic, universalizability, and a prescriptivist golden rule, looking at spectral issues in this model way has the benefit of a more umbrella-like balance. In real life, many factors may inform decision-making which are often, contemporary literature suggests, more complex.

> "People should aim to treat each other as they would like to be treated themselves – with tolerance, consideration, and compassion." (Golden Rule)

2.8.11 Case-by-Case Moral Reasoning

There exist many reasons why people undergo abortion procedures, and it is depending on these that often its reasonableness is determined. Briefly 'touching base', let us recap on the evidence to date, the most comprehensive review of which was provided by Chae et al. (2017). In a systematic review of demographic and reproductive health surveys originating in 14 countries their conclusion was that in most countries, the most frequently cited reasons for having an abortion were socioeconomic concerns on limiting childbearing. A more thorough overview of findings is provided in Appendix 8. With some exceptions, little variation existed in the reasons given by women's socio-demographic characteristics. This is relevant to a thesis on moral reasoning because of the varied responses to CO, dependant on the reasons for the abortion for some, if not all of midwives, discussed by participants.

Rather than why, some of the American literature focuses on "Who has abortions?" (Jerman et al. 2016). Although there has been a 13% decline in US abortion rates between 2008-11, the characteristics of those undergoing abortion have remained more or less constant. This research looked at the characteristics of patients – 60% of whom were in their twenties and 25% in their thirties. Almost two-thirds of that proportion had had a previous birth (59%). No one ethnic group was more represented statistically, although 39% were white. Interestingly, 94% of those participants studied were heterosexual, and this study demonstrated the first appearance of sexual orientation in data collection. All respondents were less likely to have health insurance, which shows the significance of income in decision – making but these figures could disguise possible discrimination healthcare professional factors affecting the decision-making process for the poor, one could reflect.

In enquiry to Mexican physicians, Fiala et al. (2017) established a range of differing moral beliefs about the causes of abortion and showed how this may impact on doctors' CO. For example, 71% of Mexican physicians stated they only would agree to preform

abortion for rape, 85% if the woman's life was at risk and 70% said they would if there was a fetal malformation.

Magelssen (2011: 18) also looks at "When should Conscientious Objection Be Accepted?" and illustrates the criteria for this. Magelssen suggests freedom of conscience is more plausible if seven essential features are met:

1. Providing health care would seriously damage the health of professional's moral integrity by a) constituting a serious violation b) of deeply held conviction

2. The objection has a plausible moral or religious rationale

3. The treatment is not considered to be part of the health professional's work

4. The burdens to the patient are acceptably small in that a) it is non – life threatening b) refusal does not lead to the patient getting treatment c) measures have been taken to reduce the burden to the patient

5. The burdens to colleagues and health care institutions are acceptably small

6. The objection is founded in medicine's own values

7. The medical procedure is new or of uncertain moral status

Generally, Magelssen offers a more societal view of freedom of conscience not dissimilar to the communitarian ethics later discussed. In justifying whether refusal is warranted or a serious violation of rights and convictions, Magelssen's work is a useful insight for the benefit of this debate. His thematic analytical tool is particularly relevant. His presumption that "substantial reason is needed" relates to competent decision-making, capacity, and case-by-case distinction.

More UK-based, statistics show that medical cases of abortions account for 51% of the total number of abortions. Yet it is noteworthy that in 2014, actually only 3,099 abortions (2%) were under grounds E (namely with a risk that the child would be born handicapped) (DoH 2016). Critics query if the law is being "tweaked" to provide legal loopholes because of the inability of the Courts to keep abreast of technological advances and demographic changes, cultural trends, and societal expectations of the NHS. One might then question if healthcare professionals' objection to performing abortion for one patient but not another is an extension of the four-criterion outlined in

the Abortion Act. For the reasons cited by practitioners for and against CO, see Fleming et al.'s (2018) trajectory in Appendix 9.

Gensler's (1986) Kantian views of conscience advocates consistency, logic, universalizability, and a prescriptivist golden rule, as we have seen, draw attention to Singer's 'principle of equal consideration of interests'. Like positive discrimination, this does not dictate equal treatment of everyone as the same since different interests warrant individual attention. Gensler justifies treating different interests differently, weighing factors accordingly by 'diminishing marginal utility', an idea born of Bentham. Although the thesis aims to examine moral reasoning, one of its limitations is that it is unlikely to produce universal ideas on this basis. Instead, it is hoped to achieve insight into the rationale of CO. It will explore making policy more responsive to meet the CO needs of all practitioners, support moral reasoning to enact meeting all abortion needs without ardent refusal. The responsiveness of organisations in effecting these principles, articulated in policy, is now to be examined.

2.8.12 Institutional Conscience

Whether healthcare institutions can have consciences which can be violated is the subject of Symons (2020) thesis, who argues they do not, nor should they be subject to emotional sanction en aggregate. He reminds us that conscience is essentially an introspective concept, and that institutions, comprising as they do, several moral agents, are non-homogenous. He also questions if they should be afforded legal entitlement to conscience rights. However, Symons supports permissibility on the basis that institutions can then protect their integrity, as an extension of the individual's, with harmful consequences if not for society, in general.

Cholbi (2018) analyses the flipside of the argument. He coins the stark phrase "public cartels or private conscience" (Cholbi 2018: 356) to highlight how as professionals, conscientious objectors often act in unison. Within an institutional context, for example by using licenses, regulation, sanctions, and taxation, Cholbi sees CO as failing to provide socially important goods and services en masse rather than in wanton, vigilante violation of duties. This is an opinion elaborated on in Fernandez-Lynch's book (2008) and by Wicclair (2011: 79). Arguments rest on the reciprocal "social contract" professionals are afforded, in which physicians maintain "monopolistic privilege". Wicclair distinguishes between the "commercial transaction" of the clinician: patient relationship (as a contractual agreement) and a "nourishing covenant" (Wicclair 2011:

80) (incorporating a higher level, altruistic motivation). He warns against the dangers of disregarding patient interests if doctors are given a ‘carte blanche’.

Institutional conscience is not a mission statement; it is not a singular organisational value; policy or consensus. Institutions are still bound by CO conventions and ethical principles. The healthcare professionals who practice there, according to oath, could be said to still have an affiliation to values and codes of practice, upholding moral precepts and a common identity. The contradiction is whether acting unilaterally within their organisations’ confines is unethical. Others see this as a right to be supported and protected legally and professionally. The balance is between the greater good and individual autonomy. Sulmasy (2008: 18) would seem to answer these questions using definitions of ‘tolerance*’* and its boundaries. Within the context of two-sided conflict, tolerance is “a mutual respect for conscience”, he states,

“We must acknowledge that disagreements are inevitable. Call this moral realism tempered by epistemic moral humility.”

In a pluralist society, diversity is to be valued in a workforce, especially if that society advocates democracy and inclusivity, critics suggest. Institutional conscience, *en masse,* affects accessibility and availability of a patchy service, which may be found objectionable to a certain number, including Schuklenk and Smalling (2017), but it is not illegal.

Albeit seen by some as an unethical source of moral distress in themselves, organisational solutions protect healthcare professionals and patients alike, others argue (Fernandez-Lynch 2008). Through the ideal of ‘matching’, licensing boards, calibrating supply/demand of reason-giving practitioners and appropriate, legitimate referrals, CO can then be properly regulated and monitored. Where conflicts of conscience arise in healthcare, institutions can provide a compromise, she suggests.

Although the crux of the argument of Wicclair (2011) is that professionals should be at liberty to rely on moral values to guide ethical decision-making, he pioneers the case of CO as an instrument that can be used for the greater good, the essence of professionals functioning as a profession. In this sense, discussion will focus on the duties of professionals, integral to commitment to a certain set of values.

2.8.13 Aggregate Duties of Healthcare Professionals

Shanawani (2016: 384) considers the role juxtaposition of patient, midwife, and employer. In their organisational duties, the author questions,

i) What are the allowances and limits of the exercise of objection against patient rights to receive care within accepted practice?

ii) In a society where personal/private rights exist, what are the limits of civil or public responsibilities?

iii) What is the role of institutions and what defines private, public, and civil space?

This highlights the boundaries between private and public roles, which in conscientious objection become blurred and challenging. Buchbinder et al. (2016) acknowledge the potential for viewing conscientious objection as “grounding decisions” in terms of two distinct possibilities. Conscientious refusal: violating laws of institutional policies as morally compelled to do so; and conscientious compliance: using procedural or relational constraints strategies. Organisations too must be guided by ethical principles of beneficence and non – maleficence. But perhaps corporate bodies have a stronger sense of duty of care, with a vicarious liability to match their economies of scale as well as a sense of the greatest happiness of the greatest number. As more representative of the majority, therefore, organisations may be better placed to facilitate the rights of minorities, albeit favoured by the strong to fairly justify their viewpoint. Robust infrastructures have bargaining power and as such cannot only vocalise but enact moves in support of positive change. This reasserts the role of trade unions and representation in administration of freedom of conscience procedures. Ethically it links to the principle of utility, the greatest happiness of the greatest number. For an overall majority, organisations have the potential to gauge the harmonious interests of both providers and patients in balance. Streamlined, finely tuned, pre-emptive and sophisticated mechanisms should provide alternatives which are inclusive and diverse or conversely give free rein to patient prerogative. A well-functioning health system should take in to account all sides.

In conclusion, there should be within healthcare systems enough flexibility to be able to accommodate self and society. According to Buchbinder et al. (2016: 29), ”reframing” this is at a zenith, a unique time and opportunity exists to ”chart an ethic pathway”. It makes sense to nurture conscience. In the same way as theories of moral psychology urge independence of reasoning, Sulmasy argues, so problem-solving should be treated as a well-tuned and more rounded way of dealing with CO: to maintain integrity in wholly

uncertain times (known as *akrasia*). This self-reflection and internal bargaining that accompanies objection, will be termed in the thesis, “navigating with a moral compass”.

2.3 Theme 2 - Navigating with a Moral Compass

2.3.0 The Importance of Morality in Midwifery

Einstein is often attributed with the comment,

“The most important human endeavour is striving for morality in our actions. Our inner balance and even our very existence depend on it. Only morality in our actions can give beauty and dignity to our lives.” (Dukas and Hoffman 1981: 1),

Beyond keeping within the law and professional guidance governed by them, in midwifery, morality adds an ethical dimension, making decisions logical, just, and fair. Rules and codes of conduct amongst practitioners designed to maintain standards, competence, and integrity, ensure ultimately the inherent dignity and worth of the patient (Haddad and Geiger 2021).

The International Confederation of Midwives’ Code of Ethics (ICM 2024: 1), which also mentions moral status, takes a predominantly rights-based approach,

“This code acknowledges women as persons with human rights, seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect, trust and the dignity of all members of society.... These mandates include how midwives relate to others; how they practise midwifery; how they uphold professional responsibilities and duties; and how they are to work to assure the integrity of the profession of midwifery.”

In terms of conscientious objection, it continues to outline a mutuality in midwives’ rights, but also responsibilities,

“Midwives may decide not to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.” (ICM 2024: 2)

In highlighting the *duty* to refer, the guidance reiterates the scope of professional practice and sets the context for multi-disciplinary team working. The fact that in such an important foundation document, freedom of conscience features so categorically, demonstrates the value midwives attribute to its free expression. Addressing morality, as controversial as it can be, is recognised in midwifery and further, how morally contentious some of the lived experience of ethical dilemmas can be within that practice.

Megregian et al. (2020) looked at midwives' experience of ethical dilemmas in the wider context of their learning. The main challenges related to negotiating inter-professional relationships and protecting/promoting autonomy for women which they identified as an 'unease' – a sense of distress identified in three subthemes: *uncertainty of action, compromise in action* and *reflecting on action.* Although the paper highlights how the mechanisms of tacit knowledge about right and wrong impact on care, as a retrospective study, it does not explore the relationship between clinical decision making and moral reasoning. One thing it does do, however, is highlight gaps in the current body of knowledge, identifying where the key sources of ethics learning may fall short in their support of preceptors as role models in dilemma-ridden scenarios and as reflective practitioners.

2.3.1 'Downplaying' The Role of Moral Integrity

According to Wicclair (2011: 4-5),

"Moral integrity refers to the sphere of one's core, self-identifying values that are central to the notion of conscience."

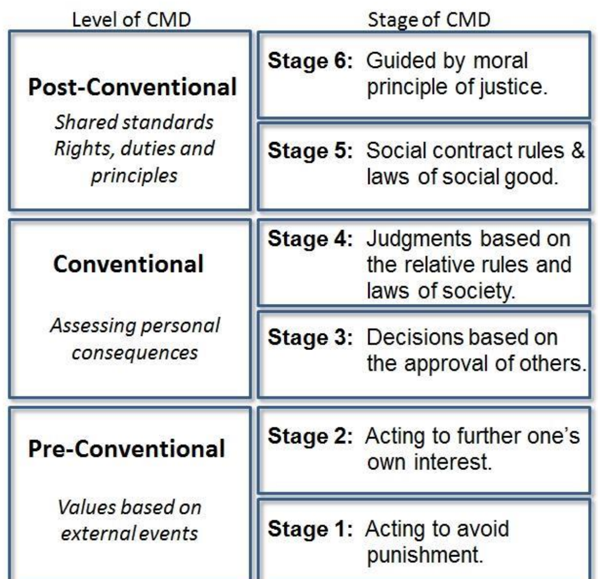
If moral distress is what the sufferer says it is, then the concept of morality is by character, truly idiographic. In IPA tradition, in any given context, morality remains self-defining. What this means is that one person's moral blueprint may contradict another's. To this end, Megregian et al. (2020: **525**) describe it as a 'challenging and complex conflict' but one seen by Giubilini (2014) as a paradoxical, 'anaemic' concept which should be left out of the healthcare debate entirely. The plurality of (bio)ethical views makes any option other than compromise feasible, Giubilini argues. Compared to objections which are based on whether a procedure is safe or beneficial, moral integrity pales away into insignificance. As a justification, the argument is weaker. Claims by healthcare practitioners to have their moral integrity respected contradict reasonable pluralism, Giubilini suggests.

Under the Rawls' principle of reciprocity (2005: 45-50), health care practitioners are granted the 'right to stick to their deeply held moral or religious beliefs'. As long as professionals grant the same right to anyone else (requesting or providing the controversial treatment), their beliefs are not intolerant (Sulmasy 2008) and do not violate plausible requirements of social justice (Brock 2008; Sulmasy 2008). It seems logical to then question how the concept of morality evolves.

2.3.2 Theories of Moral Development

Kohlberg's (1958) theory extended Piaget's (1932) account of moral development. A contemporary psychoanalysis, Kohlberg explained morality as an 'internalisation of external/cultural and internal/parental rules'. Morality is taught in stages using reinforcement, punishment, identification, and authority. Individuals may change levels, driven by frustration or recognition of each level's limitations, through infancy (for example, stage 1 – how can I avoid punishment?) to operational thought (stage 6 – what if everyone did that?)

Table 2: Theory of Conventional Moral Development (Kohlberg 1958)



Level of CMD	Stage of CMD
Post-Conventional *Shared standards Rights, duties and principles*	**Stage 6:** Guided by moral principle of justice.
	Stage 5: Social contract rules & laws of social good.
Conventional *Assessing personal consequences*	**Stage 4:** Judgments based on the relative rules and laws of society.
	Stage 3: Decisions based on the approval of others.
Pre-Conventional *Values based on external events*	**Stage 2:** Acting to further one's own interest.
	Stage 1: Acting to avoid punishment.

Good governance accompanying liberty and justice, allows opportunity to realise the supreme inherent value of morality. From an obedient orientation, through conformity, morality develops to higher stages of social contract and the application of universal ethical principles. In recounting stories, the most famous of which is detailed below, Kohlberg exposed children's interpretation of moral dilemmas.

Figure 4: Heinz Dilemma (Kohlberg 1958)

Heinz's wife was dying from a particular type of cancer. Doctors said a new drug might save her. The drug had been discovered by a local chemist, and the Heinz tried desperately to buy some, but the chemist was charging ten times the money it cost to make the drug, and this was much more than the Heinz could afford. Heinz could only raise half the money, even after help from family and friends. He explained to the chemist that his wife was dying and asked if he could have the drug cheaper or pay the rest of the money later. The chemist refused, saying that he had discovered the drug and was going to make money from it. The husband was desperate to save his wife, so later that night he broke into the chemist's and stole the drug. Was Heinz right?

Criticism of Kohlberg centred on the over emphasis on justice to the exclusion of other moral values. Presumably, this relates to moral values such as kindness, courage, humility, honesty, truthfulness, integrity, respect, hard-work, tolerance, compassion, empathy, and inclusivity. Together these may seem definitive but are by no means exhaustive. The overlap of stages (which more properly could be regarded as 'domains') do little to convey the rationalisation that accompanies intuitive decision-making, which by very nature is personal and introspective. A seventh stage labelled 'transcendental morality and cosmic orientation' links in religious and spiritual moral reasoning. But that is not to deny that individuals in earlier domains may not experience this, albeit unpredictably. The model is that inconsistent. Kohlberg hypothesised that moral behaviour was more responsible from people at higher levels, whereas perhaps everyone's motivation was different, and experience depended on a multitude of factors, not simply maturity. Knowledge, personal experience, and learning contribute to moral development, where children are not passive recipients of information. Like knowledge, which is self-acquired, functional psychology is self-directed and problem-solving, a more socio-centric view would conclude (McCleod 2013). This forms part of John Dewey's moral philosophy, which later features. What follows now is an alternative view to Kohlberg's.

A critic of Kohlberg for his androcentric, patriarchal worldview, Carol Gilligan's theory of moral development also looked to justice-based theory but balanced this with a care-based ethic. She studied subject-object problems, concluding that ethical relationships were essentially male-female. Gilligan's (1972) hypothesis (that women form their ethical and moral foundation based on how their decisions affect the lives of others),

gave rise to gender difference psychology. This purports that sexes think differently, particularly when it comes to moral philosophy, resulting from social influences.

Gilligan refuted Kohlberg's claims (that men reached higher levels of moral development sooner because of advantageous gender bias). Instead, she placed greater emphasis on compassion, caring and relationships, far from the logic and rules of Kohlberg's focus. Like Kohlberg's model, however, Gilligan's morality of care moved from considerations of one's own well-being to others. Just as Kohlberg used narrative examples, so did Gilligan to aid in the development of a theory that argued women and men may have differing paths to moral development.

Transcending from survival to integrated caring, at more advanced stages, moral choices take account of everyone. The strength of Gilligan's theory is in its comprehensiveness. Its emphasis is on fairness and rights, as an aspect of moral justice, rather than moral belief. From selfishness, through sociability, to principled morality, traces of Kohlberg's work are echoed, yet Gilligan goes further in terms of interconnectedness and universality. Morally 'just' choices are thus made by autonomous individuals, whereas in a care-based model, these may be viewed less at the expense of others. Morally good choices would thereby reconcile conflict.

Feminists are divided over Gilligan's work. While some have praised it, others have criticised it for reinforcing traditional notions of femininity that could continue to lock women into care-giver roles. A post-feminist view might suggest that diverse and nuanced, typically masculine and/or feminine traits are present is us all. A more modern perspective might accredit the values which unite us as people, not divide us as sexes. People with morally valued and irrefutably, morally valuable qualities.

2.3.3 Value Judgments

John Dewey (1859-1952) believed that neither traditional moral norms nor traditional philosophical ethics were able to cope with the problems raised by the dramatic transformations of his day (Anderson 2019). Dewey saw traditional meta-ethics as seeking to discover and justify fixed moral goals by dogmatic methods, preoccupied with reducing the diverse sources of moral insight to a single fixed principle in a futile search for certainty, stability, and simplicity. His educational psychology theories of 'learning by doing' were applied to ethical reasoning. Dewey purported that reflective intelligence be used to revise our judgments in light of the consequences of acting on them. Dewey saw improving *value judgments* as tools for guiding conduct with values that are esteemed

and prized thereby satisfactorily redirecting conduct when habits fail (socially shaped dispositions which are characteristic of personality so difficult to modify); tools that can be evaluated, estimated, and appraised in an ongoing process. If education instils habits of independent thought, then ultimately intelligent conduct will result through critical inquiry, experimentation, and creative imagination. A symbiotic reflection on the role of value judgments in CO moral reasoning, Anderson (2019: 2.3) states,

“The proximate and constitutive end of a value judgment is the resumption of activity that has been interrupted by a problematic situation; judgment has a remoter end: of using the action decided upon as a means for uncovering new evidence about what to value.”

According to Dewey’s *theory of connected experience*, an experience is a connection between what we do to things and what happens to them or us in consequence. This has important implications for understanding conscientious objection, precisely because of this inter-connectedness. Abortion-based decisions rely heavily on value judgments. Whilst this may bring some clarity, it does not determine who is responsible for what in participation and to what degree abortion decision-making is shared, which remains fallible.

2.3.4 Moral Imagination

The term ‘moral imagination’ originates in Edmund Burke’s (1790) ‘Reflections on the Revolution in France’ though ‘moral sentiment’ can be traced back to Adam Smith (1759). His stoic work on conscience is of continuing importance and an influence on Christian ethics (Raphael 2007). The ‘impartial spectator’ which is his central concept, is an imagined ‘man within the breast’ whose approbation or disapproval makes up our awareness of the nature of our own conduct. Actually, the impartial spectator is another form of the ‘invisible hand’ which determines if acts are for proprietary and merit. According to Smith, conscience is not a mysterious or inexplicable force, since,

‘‘The jurisdiction of the man within is founded altogether on the desire of praiseworthiness and in the aversion to blame-worthiness’ which underlies our ‘dread of possessing those qualities, and performing those actions, which we hate and despise in other people’’ (Theory of the Moral Sentiments, iii. 2. 33)

Explained by Raphael (2007: 3),

“As spectators of the actions of other people, we can imagine how we would feel in their situation. If we would share their motives, we approve of their action. If not, we disapprove. When we ourselves take an action, we know from experience what spectators would feel, approval or disapproval. That knowledge forms conscience, an imagined impartial spectator who tells us whether an action is right or wrong.”

The impartial spectator is a tool through which individuals divide themselves into the “judge” and “the judged” to examine their own conduct in an unbiased manner (Shin 2015) but any absolute objectivity is debateable in any human science, in any third party but even more so in an intrinsic way, as Shin implies.

The importance of self-command features in Schulenberg (2015: 145) who looked at the role of imagination in making moral judgments by questioning:

- Is there a moral way the world is?
- Do we have to be adequate in moral matters?
- Do we need firm and trans-historical standards, laws, and principles to decide moral questions?
- Is it necessary to turn those firm laws and principles to systems in ‘moral theory’ to make deliberation possible?
- Does moral theory need immutable or indubitable foundations?

Schulenberg suggests a Dewey-type pragmatic, naturalistic and humanist response would be, ‘no!’, that ideals are not fixed and the quest for the certainty of pure knowledge is futile. To avoid claims of moral chaos, which Dewey says are mostly unfounded, moral imagination and creativity should be used to discern moral truths, to develop moral responses and lead to unhindered human progress. Dewey’s ideas determine a sense of morality in one’s own actions, but in CO terms, become rather more convoluted when taking actions (or indeed omitting actions) that may affect the lives of others. To see fair play and justice in a harmonious balance of conscience rights, properly understood, recognised and regulated is the desired outcome for this study.

Gauging actions in terms of possibilities and their potential outcomes is part of the mechanisms of the moral imagination. Reflecting, discerning and internalising questions such as ‘What if?’ and ‘How come?’ moral imagination helps minimise the maleficent and maximise the beneficent, but this is infinitely subjective. Generating the most useful

of ideas, in the service of others, requires empathy, awareness, insight and a desire to see right accomplished which is where ‘moral conscience’ comes into play.

2.3.5 Moral Conscience

The two concepts of morality and conscience are so closely linked that the terms are often used interchangeably. O’Shea (2018: 582-583) outlines the difference,

“Conscience consists in a consciousness of moral demands upon the particular individual in their own specific circumstances rather than a merely abstract knowledge of right and wrong. This consciousness has also typically been taken to underpin judgments of conscience that can motivate action and foster changes in character. In short, then, conscience is an evaluative self-awareness which aims to produce particularistic and motivating moral knowledge.”

O’Shea challenges the individualism and neutrality of moral modern conscience, justifying that integrity is only a responsive barometer within a moral and social context, not by select proxy. He states,

“Conscience, so understood, is a matter of shared ethical horizons rather than individualised, divergent ones.” (O’Shea 2018: 585)

A person’s commitment to positive, social interactions, or *moral engagement*, therefore, is deemed as a connection between a moral self-view and behaviour dictated by what it is acceptable to do, or not, towards others.

For the purposes of this study, it is important to situate both with one’s ethical position, within the following theoretical frameworks – relativism, subjectivism, objectivism, and constructivism. This will determine whether one considers moral conscience as inwards or outwards-looking when linking thought and action.

2.3.6 Relativism

Moral relativism is the view that moral judgments are true or false only relative to some particular standpoint (for instance, that of a culture or a historical period) and that no standpoint is uniquely privileged over all others. Relativists often do claim that an action/judgment is morally required of a person. For example, if a person believes that abortion is morally wrong, then it *is* wrong – *for her*. In other words, it would be morally wrong for Susan to have an abortion if Susan believed that abortion is always morally

wrong (O'Sullivan and Pecorino 2002). The purpose of leading the debate henceforth is to demonstrate the theory behind what works well for one person, might not be the case for another. A relativist perspective on CO justifies and throws light on ambiguously grey areas of case-by-case scenarios, criticised for being discriminate, inequitable, and inconsistent. It is these flaws which the incompatibility thesis holds, render the concept of CO as open to abuse and thereby invalid. Beckwith (2007), although broadly speaking presenting a pro-life argument, offers a case against moral relativism in his argument that there are,

"Objective moral principles that apply to all persons, in all times, and in all places" (Beckwith 2007: xiii).

2.3.7 Objectivism and Popper's Principle of Rationality

According to Popper's rationality principle, agents act in the most adequate way according to the *objective* situation. They learn in an evolutionary way, by 'trial and error'. It is an idealized conception of human behaviour which he used to drive his model of situational analysis. Individual actors and their relationships to bureaucratic institutions form the 'logic of the situation'. This results from reconstructing meticulously all circumstances of an historical event. The 'principle of rationality' is the assumption that people are instrumental in trying to reach their goals, and this is what drives the model. Popper believed that this model could be continuously refined to approach the objective truth (Palacio-Vera 2020).

2.3.8 Constructionism

By comparison to the objectivist idea that meaning exists in the world, in constructionism, meaning is attributed to our interactions with the world (and others). In this philosophical epoch, tangibility involves reshaping modes of reality through social collaboration, building new understandings as an active engagement in learning experiences. Scaffolding, guidance, and support, play an important role in the learning process of moral development. A constructionist view of CO might, for example, suggest that one's position is a product, constructed of one's previous experience. Learning about CO may be the result of one's prior ethical decision-making and moral dilemmas. There are pros and cons of this view. On a positive note, one may be empathic and reflect more constructively, in a problem-solving way, having come through it. Conversely, buckled by the weight of one's own conscience, one's perspective may be distorted to patient-centredness and ultimately biased in value judgment.

2.3.9 Subjectivism

In philosophy, subjectivism relates to the concept or doctrine that knowledge is merely subjective and that there is no external or objective truth. In a subjectivist case, meaning is imposed on the world. An ethical theory, subjectivism holds that personal attitudes and feelings are the sole determinants of moral values. Subjectivism comprises of various theories holding that the only valid standard of judgment is that of the individual. For example, ethical subjectivism holds that individual conscience is the only appropriate standard for moral judgment. The doctrine surmises that all knowledge is restricted to the conscious self and its sensory states. Subjectivism is a theory that emphasises the subjective elements in experience, that reality is created or shaped by the mind and epistemological knowledge is based in feelings or intuition.

One of the main proponents, the philosopher Max Stirner (1806-1856) had considerable international influence as the outstanding German "theoretician of anarchism." Stirner's philosophy maintained that only the individual counted: He was the centre of the world, and his thoughts and feelings determined the scale of social and, specifically, moral values. Outside the individual nothing existed but the creation of the individual. Stirner's philosophy represents probably the acme of subjectivism in the history of philosophy of the Western world (Edward and De Ridder 2011).

Stirner was against all social conventions and opposed all the philosophies of his time that were known to him, including German idealism, French materialism, British empiricism, and international socialism (communism).

2.3.10 Perspectivism

Perspectivism (also called perspectivalism) is the epistemological principle that perception of and knowledge of something are always bound to the interpretive perspectives of those observing it. While perspectivism *does not* regard all perspectives and interpretations as being of equal truth or value, it holds that no one has access to an absolute view of the world cut off from perspective (Nehamas 1998). Nietzsche's famous pronouncement that "God is dead" implies, among other things, that the idea of a transcendent or objective justification for moral claims—whether it be God, Platonic Forms, or Reason—is no longer credible. He explicitly embraces a form of perspectivism according to which "there are no moral phenomena, only moral interpretations of phenomena" (Nietzsche 1886: 108) as there is, he purported, a no sense of objective truth. Nietzsche argued that knowledge is contingent and conditional

and his Existentialist philosophy on morality was based on his perception of good and evil, given his assumptions about the end of religion in the modern world. In this regard, of course, CO is not solely a religious notion. Nietzsche was famed for uncompromising criticism of conventional pieties, which he believed were exposing a false consciousness, infecting people's received ideas and smothering them with self-loathing. For this reason, he is associated with thinkers including Marx and Freud in the 'Hermeneutic of suspicion' who were committed to unmaking lies and illusion of consciousness in a distinctly modern style of interpretation that circumvents less obvious truths and draws out sublime meanings. The expression "hermeneutic of suspicion" is a tautological way of saying that words may not always mean what they seem to mean. In his nihilist rejection of all religious and moral principles, in the belief that life is meaningless, Nietzsche is often viewed as a radical philologist, whose remarks about the master-slave were often a tragic indictment on manipulation,

"The trodden worm curls up. This testifies to its caution. It thus reduces its chances of being trodden upon again. In the language of morality: Humility." (Nietzsche 1889: 8)

Nietzsche's critique of moral values rejects morality because it is 'disvaluable' namely, not such a good thing which prevents a capacity for a well-ordered soul and a capability to live a higher life.

It is true that Nietzsche liked to rank moralities according to whether they are expressions of strength or weakness, health, or sickness; but he did not insist that the criteria of rank he favoured constituted an objectively privileged vantage point from which different moralities can be appraised. In the appraisal of different moralities, the concept of moral complicity is often put forward.

2.3.11 Moral Complicity

This maintains to what degree an individual can be held accountable or is culpable for the unethical, immoral, or criminal acts of others, along the lines in law of double jeopardy. Wicclair (2011: 36) elaborates on moral complicity in support of conscience absolutism, amongst healthcare professionals. As moral agents seeking to preserve moral integrity in acts of perceived ethical wrong-doing, Wicclair categorically distances direct and indirect referral and draws attention to the inconsistencies between assisting patients. He quotes Karen Brauer, President of Pharmacists for Life, who refers to moral complicity arguments as,

"That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does', what's that saying? 'I know a buddy who will'?"

Orr (2007) highlights factors that may be used in relative assessment of moral complicity: *timing* (has the act already been completed?); *proximity* (is the cloud of culpability for a single act shared by many individuals?); *certitude* (to what degree is it certain that the act is in the past?); *knowledge* (did the complicit individual have prior awareness of the act?) and *intent* (what was the part in the decision-making surrounding the act?). Orr provides colourful examples to illustrate his argument – cadavers used from Nazi death camps for medical teaching, vaccines development from aborted fetuses – to which it may be possible to add further categories – *initiation (*what and who was the starting point?); *perpetuation* (did the individual do nothing, perpetuate the wrong doing or make a stand?) and *insight* (not only were they aware but did they have capacity for moral reasoning to judge the wrong-doing of the act?). Orr concludes with his thoughts on spectrum of belief about moral complicity. He points to an analogy on which our analysis of CO would do well to draw,

"Thus, two people of faith may arrive at different conclusions about when it is appropriate to invoke this right. Such variation is fundamental to the concept to an individual's conscience." (Orr 2007: 24)

In the main debate over abortion, one of two of the proximal conclusions are traditionally drawn, questioning whose rights are right and whose rights ought to take precedence. CO, however, adds in a third dimension – those of the practitioner. If their role is morally complicit, which according to the tenets of Orr's argument above, not all commentators maintain, then the following theme looks at the potential of harms being inflicted from a neonatal perspective.

2.4 Theme 3 - Fearing Reviving, Surviving and Thriving

According to the ONS (2021), the proportion of abortions that are performed at under 10 weeks has continued to increase since 2011. In 2021, 89% of abortions were performed under 10 weeks, increasing from 88% in 2020 and 78% in 2011. The percentage performed at 20 weeks was 1% in both 2020 and 2021. The legal limit for a woman having an abortion is 24 weeks gestation. This is the point at which the fetus is currently deemed viable outside the mother's body. Abortions may be performed after 24 weeks in certain circumstances, for example, if the mother's life is at risk or if the child would be born severely disabled. Abortions where gestation is 24 weeks or over account for a

very small number of abortions (0.1% of the total). There were 276 such abortions in 2021. For midwives' moral reasoning, these considerations impact on their rationalisation of 'harm' and the degree to which there are elements of moral complicity in taking a life, bound up with the idea of personhood.

2.4.1 The Idea of Personhood

The idea of personhood is central to healthcare. Until it is born, the fetus has no legal rights. That is not to say that the fetus is not a factor to be considered medically, physically, mentally, socially, emotionally, psychologically, morally, and even, financially, or in certain societies, economically. This idea of a "morally significant life" pervades through the work of Mackintosh (2014), for whom problems associated with the idea of personhood lead her to promote a rather more inter-dependent and collective view of "Communitarian ethics". For Mackintosh, relationships and membership in society are wholly important in a communal view that blurs the boundaries of inclusion. Taking it further, communitarian ethics also smudge the limits of individuality. Various accounts of personhood are listed below:

Table 3: Accounts of Personhood (Mackintosh 2014: 26)

Biological	refers to a realism and self – sustaining, scientific concept of the fetus as an organism, distinguishing between life and death
Psychological	a functionalist and qualitative view of the person with qualities of awareness, conscious and experiential
Substantive	refers to constituted human beings with relationships to others in a social construction
Theological	man is man in God's image and the pinnacle of His creative processes which relates to the sanctity of life and ensoulment
Existentialist	Post – war emphasis is placed on the individual with uniqueness and their situation in life which captures the essence of their humanity

Mackintosh's work focuses on exactly the care ethic phenomenology, what Mackintosh terms, "relational ethics" – referring to the concepts of love, empathy and compassion. This socio – cultural view adopts a "lived world" reality. She endorses a far richer way of looking at the world, embedded in society, rather than a self-determined autonomous being.

Cantens (2019) is more specific about personhood, although it is only possible to approximate and the evidence is inconclusive, they admit. They detail five traits which afford personhood status to aliens: consciousness; reasoning; self-motivated activity; communication and self-awareness.

This differing vision of personhood is relevant to our debate as it gives us an idea of the justification that midwives may use helping to rationalise what they do and why (and indeed, why not). Adherents to a defence of abortion may maintain that a fetus in pregnancy is not only human life, but accrues status as a person, though not capable of sustaining independent life, which leads to the question when does life begin?

2.4.2 When Does Life Begin?

Human life has been claimed to begin at various points, believes Gensler (1986: 84): at conception; when individuality is assured (as a zygote, it cannot split or fuse with another); when the fetus exhibits brainwaves; when the fetus could live apart; at birth; or when the being becomes self-conscious and rational. This is different to the idea of personhood, which infers a naturalistic view that grants moral consideration to all sentient beings (*sentientism).* In a genetic sense, homo sapiens life is very much an infant idea to what Gensler calls "sense" and "intuitions". This means that as a member of our fellow human species, one has a sense of common humanity in deciding about its life but an intuition that abortion does not equate with infanticide, as Gensler explains the concept.

By the same token, some may view pregnancy as a conceptus; an implantation; a biological organism; an embryo; a gamete; a fetus; a living embodiment; a new life; others, a baby. The position adopted is a matter of personal conviction, individual preference, and political persuasion. This is not a new slant – it features heavily in ancient texts. Nowadays in a pluralistic health care environment, terminology is still evolving.

It would be useful to establish this from the outset, to establish if we are going to abort, what exactly we understand by the life we are terminating. Does respect for embryos entail respect for gametes? asks Gomez-Lobo (2004), for example, at what gestation is that termination considered to be human life? This "thought experiment" (Cantens 2019: 30) forces us to think outside of our community and, he states,

“Make these alien beings worthy of respect and membership in a moral community, despite not being human.”

Using a first-person perspective in this way is a phenomenon termed by Cantens (2019: 23) as ‘the undeveloped cognition argument’, presumably so termed because every fetus is characterised by a lack of capacity for independent thought and understanding.

The ‘Peter Singer Journey Model of Life’ (Lazari-Radek and Singer 2014) advocates the taking of life at its beginning when no goals have been set. At the earliest opportunity, there is less wrong because as a person, there have been no accomplishments. Singer’s principle: if we can prevent something from happening without sacrificing anything of comparable moral importance, then we ought to do so, denies the automatic right of the fetus to life. Singer’s principle also dismisses potentiality as well: that cognition is developing.

Savell (2007) suggests that advances in 4d imaging in pregnancy of the fetus by visualising realistic facial likenesses, has revolutionised the idea of personhood. The fetus, in 4D is “responsive…capable of complex behaviour” and adopts very human characteristics. Savell’s work on this new departure, thereby reconfigures the adequacy of abortion laws based on the new public mind-set. With given visual and inner roof of life, a new ethics needs to be developed in a new technological age. Reform initiatives, long overdue in both the US and the UK, Savell (2007: 103) argues, have led to two concerns over,

“A shift from viability to sentience as a criterion of legal significance. The second concerns a shift toward constructing abortion in terms of feticide, as distinct from termination of pregnancy”.

Carers also view a baby’s 4D movements, see them smile, wave their hand, monitor their heartbeat. Above and beyond the call of duty, majoritarian needs of the service and society’s demands for its egalitarian nature, should still not be allowed to suppress one voice. For midwives, oft that voice is a piercing, first cry. A moment of joy to be celebrated.

In asking ‘who and what are we and can we know it?’, Beckwith (2007: **xiii**), sees the dispute over abortion not as a morality dispute, but as,

“A clash of who counts as a member of the human community”.

Presumably this relates to the notion of when life starts and what constitutes a person, with status, rights, and consciousness. Beckwith's (2007) *Moral and Legal Case Against Abortion Choice* outlines his position:

1. The unborn entity, from the moment of conception, is a fully-fledged member of the human community.
2. It is prima facie morally wrong to kill any member of that community.
3. Every successful abortion kills an unborn entity, a full-fledged member of the human community.
4. Therefore, every successful abortion is prima facie, morally wrong. (Beckwith 2007: xii).

The agency of a fetus, limited in its capacity for independent thought, moral reasoning, decision-making, self-determination, and self-care is obviously stilted because it is dependent on its mother.

An a newly fertilised ovum, an embryonic clump of cells is no more a person than an acorn is an oak tree, Thomson (1971: 48) proffers, illustrative of the argument's greyness, lacking definition. In "A Defense of Abortion", Jarvis-Thomson (1971) grants for the sake of argument that the fetus has a right to life, but defends the permissibility of abortion by appealing to a thought experiment: The Violinist's Dilemma. Later, Irwin reflects on the same question of a fetus as an offshoot, branching from its stem, for clarification,

"What is the builder to the house, the marble to the statue, the acorn to the oak, the block of stone to the threshold?" (Irwin 1990: 225).

"The violinist's right to life does not give the violinist a right to your body."

Figure 5: The Violinist's Dilemma (Thomson 1971)

You wake up in the morning and find yourself back-to-back in bed with an unconscious violinist. A famous unconscious violinist. He has been found to have a fatal kidney ailment, and the Society of Music Lovers has canvassed all the available medical records and found that you alone have the right blood type to help. They have therefore kidnapped you, and last night the violinist's circulatory system was plugged into yours, so that your kidneys can be used to extract poisons from his blood as well as your own. If he is unplugged from you now, he will die; but in nine months he will have recovered from his ailment and can safely be unplugged from you.

So, at what point, is agency possible and what criteria do we use to assess personhood? In keeping with Morgan's (2013) notion of humanness, qualities of personhood include sentience, consciousness, and rationality. How these manifest embryonically (even whether they exist at all) remain controversial.

Although one's position on abortion is underlying the philosophical, theological and moral-based arguments of CO, it's important to distinguish between the two concepts. Despite the difficulties in trying to extradite the two stakeholders, we can still learn from the violinist's dilemma. Maybe the interpretation of the inter-dependency could mirror that between healthcare provider and service-user? This study questions whether the conflict of rights, whether internal within the conscience of practitioners or between parties, need not be a battle of wills. Whilst the compatibility of being 'with woman' may seem to be in dispute in cases of CO, the mutuality of respect is not. Assumptions about doing no harm still preside, though should this include harm from moral distress, between *recipient* and *donor* (Neal 2019: 11) - whose need is greater and how is this measured?

Whilst substantial moral weight is afforded to the accommodation on the grounds of moral integrity for the practitioner, professionalism and 'proper medical treatment' is still desirable, commentators discuss (Neal 2019; Wicclair 2008). Neal suggests that this is especially so in *liminal* cases (an intervention with questionable therapeutic value or potential where there is room for disagreement).

In the exercise of moral agency, there is extensive scope for overlap between the rights of service-users and the rights of practitioners. In answering questions on CO scope and addressing concern about so-called 'conscience creep', "consent is the ideal: the

("indispensable") gold standard that we seek wherever possible." (Neal 2019: 8). Where the rights of the patient end and the rights of the midwife start remains elusive and contentious, however. Neal (2019: 2) in examining the defensible, reasonable parameters of CO to this end states,

"No-one supports an unlimited right to CO, however; all of us who recognise the need to protect professionals against violations of integrity also recognise that we cannot simply allow each individual professional complete liberty to decide which parts of her role she will perform. A principal concern uniting writers across the spectrum of opinion, therefore, is the issue of limiting accommodation for conscience: which conscience claims, if any, do we regard as valid and wish to accommodate, and which do we wish to exclude, and what criteria can be used to tell between the two?"

Restrictions on CO may be one solution, Neal argues, which include a narrower range of treatments to which one could object or a 'conventional compromise' (with a duty to refer), or ensuring objections pass tests of reasonableness and genuineness, like Card (2014) suggests. The strength of Neal's work is in support of clearer definition of categories of treatments which may be objectionable. This does go some way to answer one of our research questions – what constitutes participation? In doing so, however, one could question if the additional dimension solves one dilemma and creates another: around which 'proper' label to appoint. The following two principles may help decipher the morality aspects of the dilemma: potentiality and a future life of value.

2.4.3 Potentiality

According to Morgan (2013), the principle of potentiality was first introduced by Aristotle, who developed into "a golden rule of abortion". This theorised that the fetus *will* manifest property and realise it's potential from being a nascent entity to possess all attributes as *'full persons'* later in life, presumably, with all the rights, responsibilities and contributions that accompany it. In distinguishing between the actual and the potential, real and imagined, Morgan also makes a distinction between feminist and Catholic moral philosophy. Abortion-defenders like Thomson stand in stark contrast with and pro-life advocate, Francis Beckwith. For Aristotle, the emergence of the rational soul was the main concern, which became a focus on the moral status of the fetus in the 1970's, Morgan argues. Today's potentiality debates revolve around "life" issues, suggests Morgan, because when the US Supreme Court legalised abortion in its 1973 *Roe v. Wade* decision, it ruled that the state has an "important and legitimate interest in protecting the *potentiality* of human life from the 24th week of pregnancy". This is where

legal definitions may differ from moral, theological, or philosophical ones, prompting consideration of further criteria such as a ‘future like ours’.

2.4.4 A Future Like Ours, A Future Life of Value?

Marquis’ (1989) paper "Why Abortion Is Immoral" is widely cited in the philosophical debate over abortion. Marquis criticised general debate on the morality of abortion because of its focus on whether fetuses are human beings, or whether fetuses are persons. Instead, his main thrust was based on his account of why killing children and adults is wrong, abortion being no different. This is sometimes known as the "deprivation argument", since a central premise is that abortion deprives an embryo or fetus of a "future like ours".

Brown (2000) criticises Marquis’ view as ‘’metaphysical”, ‘‘ambiguous” and “deceptively simple”. Brown (2000: 103) disagrees with Marquis’ point, namely,

“That the fetus has a future similar in morally relevant respects to the future lost by competent adult homicide victims, and that, as consequence, abortion is justifiable only in the same circumstances in which killing competent adult human beings is justifiable.”

Precisely because of equivocation over what comprises value, who and how to judge this? Marquis (2001: 363) later qualifies definition of a life of value, as possessing,

“The goods of life we would have experienced had we survived.”

If a life of value is a self-represented concept, is a fetus best placed therefore to judge it? There may be issues which make that judgement temporal or temporary, for example, if whether a depressed person, for whatever reason can judge the value of their future soundly may perhaps raise questions around capacity.

The criticisms against a ‘future like ours’ put forward by Brown (2000) are based on the grounds that they ignore the point of view of the pregnant woman; that they are incompatible with contraception and abstinence; and that they understate the explanatory resources of the competing personhood theory while overstating their own explanatory power.

Marquis’ (2001) retort to Brown is that he misjudges ideas of welfare rights, which are not implied in the original works. Marquis justifies his argument because fetuses lack the mental state and function necessary to comprehend the possession of the right to life.

Brown's analysis would be better situated alongside desires, interests, sentience, various concepts like moral agency and rationality, Marquis concludes. Nevertheless, if one considers abortion as 'immoral', then the converse point that CO must therefore be 'moral' is still not a valid position. To support CO does not necessarily mean one is anti-abortion. One could claim to be pro-choice for all. So far, we have looked at the practitioner with faith and with a conscience. We have argued that neonatal fetal-related dilemmas occur, now let's look at professional aspects of moral reasoning and which workplace issues may arise when trying to combine the role of midwife with a personal persona.

2.5 Theme 4 - Being Torn Between Wearing Two Hats

Although the terms morality and ethics are used interchangeably in many contexts, and both reflect human relationships of mutual respect and trust, there are some differences. The difference between ethics and morals, is outlined by Hewson (2001) below,

- Ethical theories are a set of principles by which we can judge all actions
- Morals (or applied ethics) are the specifics of ethical theories. For example, "I do not want others to kill me, so I should not kill others."
- Morals explain what is right or wrong in a particular (often controversial) issue. For example, abortion, euthanasia (Hewson 2001)

Both morality and ethics are strongly underestimated in their persuasiveness, bias and ideological commitment by many conscientious objectors, according to Clarke (2019). In considering ethical principles, discussion leads from moral values to theorising on the philosophy behind systems and codes of behaviour. Whereas morality relates to a set of beliefs held by a group about how people should live together, ethics is the study of how a group defines themselves in terms of their conduct. Ethics help us seek to establish what is in the interests of the common good and make the best choices.

Urmila (2007: 58) gives a sense of the balancing act of ethics when he defines ethics as,

"An understanding of the nature of conflicts arising from moral imperatives and how best we may deal with them."

Whether abortion represents a beneficent act is so contentious that the common good is neither easily nor assuredly determined. By the same token, in CO, identifying who are

the main stakeholders may be open to question depending on personal conscience. Contextualised to CO, ethical theory will henceforth be applied to professional matters in this section.

2.5.1 Ethical Theory Applied to Conscientious Objection Decision-Making

According to Cline (2021), there are three main ethical schools of thought which govern our personal stance on anything,

“The first two are considered deontic, deontological, or action-based theories of morality because they focus entirely on the actions which a person performs.... Whereas these first two systems focus on the question "What should I do?" the third asks an entirely different question: "What sort of person should I be?".

Each of these will now be considered in turn.

2.5.2 Deontological

With regards to duty or obligation, deontic moral action relates to the Aristotelian concept of ‘*eudemonia* - a Greek word translating to the state or condition of 'good spirit'. Eudemonia is commonly translated as 'happiness' or 'welfare' and is the term signifying the highest human good. Deontological ethical systems therefore are characterised primarily by a focus on adherence to independent moral rules or duties (Cline 2021). A theory most closely associated with the maxim of German philosopher Immanuel Kant, examples of deontological, rule-based ethics are the Ten Commandments or later, the Universal Declaration of Human Rights. Kant believed it was the ability to use reason that defined a person. This essential dignity of personhood, he argued creates fundamental boundaries, motivated by respect for moral laws.

Therefore, in order to make the correct moral choices, you simply have to understand what your moral duties are but in CO, these are not always clear cut. Duties may depend on circumstances, whether a life-threatening emergency or not, for example. The shifting sands of diagnosis, gestation or justification make decision-making and problem-solving in a midwifery context rather apprehensive. Even though criteria is laid out in the Abortion Act, there is still scope for inconsistencies, brought about by the flexibility which was designed to be one of its strengths. Whilst professional bodies may acknowledge the potential for dilemmas, guidance is criticised as being incomplete or inadequate. Many judgments are open to interpretation and their realisation in practice is fraught with complexity. Is the same duty afforded to everyone and who defines those

duties? To whom is the duty of care owed, ethicists question and sometimes the stakeholders' interests may not be congruent. The woman, the midwife, his/her employer, colleagues and the profession, society and/or indeed is the duty primarily to the fetus? The 'correct' rules do not necessarily exist which regulate those duties. For example, practitioners may well satisfy themselves that in meeting professional obligations they have fulfilled legal requirements. Although they may well ask, is it legal, they also may reason is it right?

With its emphasis on consistency, Kant's theory has been criticised (including by Schopenhauer, John Stuart Mills and Frederic Nietzsche) for inflexibility, poor application to real life, practical situations, and a lack of regard for 'acts of omission'. In CO scenarios, this is where 'Threshold Deontology' may be relevant – which puts forth that we should always obey the rules unless there is an emergency, which is when we should turn to the following theory, Consequentialism.

2.5.3 Teleological (or Consequentialist)

Teleological moral systems are characterised primarily by a focus on the consequences which any action might have. Again, in CO, it is not always possible to pre-determine resulting outcomes. In fact, these may be different for various stakeholders. Imagine, for example, a practitioner who performs an abortion on the grounds of purported benefit for the woman. If she collapsed and died during the procedure, would the means necessarily justify the end? To make correct moral choices, there must be some understanding of what will result from your options, Cline (2021) suggests, which may be infinitely variable or unpredictable in CO.

One of the advantages of consequentialism is that it encourages people to be more responsible for their own actions (known as 'proactivity'), rendering accountability alongside autonomy. It has been criticised for pitting logic versus conscience, gambling outcomes which may not be always predicted. Weighing up consequences is time-consuming, alienating (Smart and Williams 1973), requires foresight and calls for rationalisation, itself a problem (Grisez 1978). Grisez (1978: 67) states,

"Situations relevant to moral choice are not like clearly distinguished scenes in a play; they are rather like scenes in a continuous landscape from which one composes a photograph. But the situation ethicist talks as if situations were predefined."

To meander this unmapped path presumably implies a role for ethical reasoning, and a navigation of decision-making at every moral crossroads. The central agent is an integral part, not an observer to the sequelae and the destination is unknown.

There are two approaches to teleological ethics depending on whether the consequences are for oneself (*egoism)* and/or others (*Utilitarianism).* Both could be considered relevant as a theory of morality that advocates actions that foster happiness or pleasure and oppose actions that cause unhappiness or harm. Benthamite principles of 'the greatest happiness of the greatest number' may be significant to CO, in the sense of the healthcare practitioner making a personal sacrifice, shouldering a conscience burden in the interests of the common good. When directed toward making social, economic, or political decisions, a Utilitarian philosophy would aim for the betterment of society. Known as 'The Principle of Utility', the idea of the maximisation of societal interests is a potent facet of the abortion debate – because it is central to the workings of democracy – unless one agrees that abortion is not 'a common good'.

The concept of common good developed through the work of political theorists, moral philosophers, and public economists, including Thomas Aquinas, Niccolò Machiavelli, John Locke, Jean-Jacques Rousseau, James Madison, Adam Smith, Karl Marx, John Stuart Mill, John Maynard Keynes, John Rawls, and many other thinkers. It refers to either what is shared and beneficial for all or most members of a given community, or alternatively, what is achieved by citizenship, collective action, and active participation. Whilst some may view the common good as the highest level of moral achievement, others may question it as a truly sound explanation of motivation, preferring instead autonomy. In some ways, the common good could be seen as unconstitutional since someone always must make a sacrifice. The Catechism notes three essential elements of the common good: respect for the individual, the social well-being and development of the group, and peace – but do these preconditions necessarily need to be present for immorality to be admonished and what constitutes a common good? Who decides and how?

2.5.4 Virtue-based

Virtue-based ethical theories place much less emphasis on which rules people should follow and instead focus on helping people develop good character traits, such as kindness and generosity (Cline 2021). Developed by Aristotle and other Greeks, this character-based, normative ethic is the quest to live a life of a moral character, acquired through practice. Studebaker's (2013) online disagreement is based on,

“There (*being)* no such thing as a good person divorced from good actions. Here’s why. To catch a mouse, you have to think like a mouse.”

Yet in CO, whether participation is a beneficent act and who is the main beneficiary is disputed. If disagreement dilemmas ensue, those ‘immoral’ acts are no more well-defined as vices since what one person may view as an evil, immoral or complicit act, another may view as a noble intention. Whether practitioners can fully admit that the participation is truly an act of kindness to the fetus calls for incredible value judgments. The onus is on the woman to be virtuous (insofar as acts are accompanied by virtue-based ethical decision-making), as well as for the midwife. In this sense, virtue-based ethics is limited because it doesn’t tell us how to act in different situations or help overcome moral dilemmas. There is no single & definitive answer to what the virtues are, they are time-changing, like the dilemmas that urge the need for them. This is where an understanding of ethical principles may be useful in problem-solving dilemmas since they can be flexibly applied to different ethical scenarios.

3. Reflexivity Pit-Stop – Ethical Stance

It seems prudent to consider my ethical stance: I started by asking myself 'what are the ethical decisions telling me what I should do? 'How do these principles guide the choices I make?' and 'What research perspective do I take in light of those choices?' Whether my assumptions about right and wrong colour allow my interpretation of the data and analysis of the findings with clarity. The tenets of ethical thinking are reflected throughout the thesis. As an 'insider', as a professional colleague, as a fellow midwife and as a team-mate, I have experienced ethical dilemmas related to participation in social abortion. I didn't like how it made me feel, standing aside. I was a learner and had assisted in Gynaecology theatre and resumed my duty of care for further cases afterwards. I'm very much more conscious of equity and ethical principles related to respect for persons, autonomy, and justice/fairness. This is something I try to practise – as I believe.

I would describe myself as a pro-choice advocate, a Feminist supporter of women's rights but I choose not to participate, nor professionally am currently called upon to. I believe in doing no harm, in doing good, in justice and fairness. Consequentialist ethics therefore is the primary focus of my ethics. This asks questions about the benevolence of one's actions, such as 'is it good'? in a way that is non-maleficent and beneficent. A consequentialist perspective is at the same time altruistic, considering the impact of one's behaviour. It also considers the greatest happiness of the greatest number, as say, Bentham might ascetically. Does the end justify the means? My inner voice frequently asks. Alternatively, a Duty-based ethics' point of view may ask 'is it right'? I'm sure this project is, given the potential to influence the lives of millions of people positively in terms of their experience of the complications of unsafe abortion. I am both owing (and indeed owed) a duty of care. Some of the conflicts posed in healthcare, I believe involve deciding on contrasting duties. The aim of reasoning therefore is very outcomes-based, to be consistent and coherent, just, and fair. Virtue ethics to inform my own ethical decision-making, avoiding vices. Virtue ethics gives guidance on how to live one's life, aspiring one's character. I would support cardinal principles – prudence, justice, temperance, fortitude, and courage. A more contemporary approach to ethics, Relational ethics situates actions within relationships interpersonally and societally. Finally, I would reflect that neither of these schools of thought are exclusive. It is possible to draw on all simultaneously ultimately in a Pragmatic approach.

2.5.5 Ethical Principles

In healthcare, there are four main ethical principles: beneficence, non-maleficence, autonomy, and justice, whose rank is sometimes open to discussion. Together these constitute the ‘4 pronged’ pillars of ethics (Varkey 2021). Since the first two are oldest, traced back to the time of Hippocrates “to help and do no harm”, they shall be considered first.

In modern times, Beauchamp and Childress’ (2013) classic exposition of these four principles and their application is pertinent to practical as well as philosophical questions of CO. From moral foundations, through moral principles to theory and method, how the four principles can be put to use is helpful to the everyday practitioner, looking for a beacon but they would do well to remember however, that ethics are by no means a perfect, or prescriptive empiricism.

Whilst the authors’ previous work (see Appendix 17) examines the role of the midwife in maintaining ethical standards, through her role as facilitator-educator-practitioner (Richards 1997), it too will be drawn upon. Criticism of the dehumanising and iatrogenic effect of the medicalised model, hospital – based, diagnostics-led and disease–orientated, have prompted a view that health should take a more woman – centred, holistic approach (Richards 1997). Relate this to SRH services and views become more convincing, given the potential to do harm to two lives of value. In terms of CO, midwives may well argue that they are demonstrating a respect for the life of the fetus: a beneficent act and an observance of non–maleficence.

2.5.6 Beneficence

The duty to ensure that their interventions are not solely sound and appropriate but above all else, ‘do good’ is the primary responsibility of healthcare practitioners. How best to benefit the patient is an “inherent and inseparable part of clinical medicine” (Varkey 2021: **18**). As a positive reinforcement, as an ethical principle, as an interpretation of the difference between rights and wrong, beneficence may still be contentious.

Beneficence is a prima facie principle related to defending the rights of others, promoting welfare, preventing harm and seeing moral right done. Varkey (2021) suggests this moral duty is a debt to be paid by the professional to society for their education, rank and privileges, yet in fulfilling women’s right to choose and maintaining

her bodily autonomy – is abortion necessarily a beneficent act? After all, social circumstances can be manipulated to change the context of reproductive health choices - in a different time or different situation, might a woman's reactions still be the same? So might therefore, the healthcare practitioner's value judgments over the justness of their participation.

The answer lies in resolving the quandary of to whom the primary duty of care lies, whose rights take precedence or need protecting most and potentially who has most to gain. Prevention of forced childbearing, unsafe abortion, poverty enslavement and reducing burdensome unwanted pregnancies could be said on one hand, to be mainly a beneficent motivation, satisfying the needs of society as well as the individual. Others argue to the contrary. Accommodation of CO ought to take account of these differences of opinion and regulate to feasibly guard against limitless extremity (both absolutist and a practitioner carte blanche).

In a paper which highlights the religious and secular moral argument, Watson's (2019) case studies focus medical ethics on CO. She articulates how analysis using 'Principalism' could thus support abortion access and destigmatise the debate. Watson guides the reader to address non-maleficence first, which (one again in 'an acorn and an oak tree' kind of way), brings us full circle to consider whether embryos and people are in the same category. At the same time, the honourable occupation of clinicians who provide abortions help patients respect bodily autonomy, decisional freedom, and the dignity of dominion over their life's course, Watson argues. This thesis would position that it is first necessary to decide whether the right to life should (and most often does) rank over identity, moral excellence, and life experience.

Maternal mortality makes the conscience burden less straightforward. Imagine if a woman dies because of an abortion procedure, can the professional (and indeed society requesting the service) weight this tragedy as an ethically sound risk in the interests of gender and economic justice even if decided by the majority? If (un)foreseen, unintended but harmful outcomes result, it is known as 'The doctrine of double effect' (Varkey 2021). Then in forfeiture, this is where the second principle comes into play:

2.5.7 Non-maleficence

Non-maleficence is the duty to 'do no harm', (in Latin - *primum non nocere)* which supports several moral rules like 'do not kill' often cited in the literature as the basis of the Hippocratic oath (Page 2012). It is balanced with beneficence to still eschew pros

and cons of interventions/treatments to choose the least harmful course of action, where some harm is inevitable. Tricky decisions are made even more elusive in reproductive health, dealing with two lives whose interests and well-being may not be necessarily commensurate, though both entities' survival still is inextricably linked. Tardiff (2015: 255) believes that the main moral reasoning centres around to whom greater harm is incurred by abortion,

"Were this principle applied to an unwanted pregnancy in which no extenuating circumstances were present, it would not be morally supportive of pregnancy termination, even with the legal acceptance of human abortion. This principle, however, should be invoked to insist that a pregnant woman not be discredited or discriminated against because of either her unwanted pregnancy or her election to terminate her pregnancy."

Recognising the potential for great harm in discriminatory practice, Tardiff illustrates like Watson (2019) how ethical principles can be applied in turn to address care discrepancies. In balancing the scales, the next principle is imperative: 'Justice'.

2.5.8 Justice

Justice as an ethical principle relates to universal fair play. According to Tardiff (2015: 255) justice,

"Seeks to achieve fairness among people when *equity* has lost, or is about to lose, its equilibrium in terms of social co-operation."

Sometimes in tense relation with respect for person's autonomy because individual wants need to be circumscribed in favour of the common good (Richards 1997), conflicts of justice are difficult to arbitrate because they are composed of objective and, more often, subjective criteria, argues Tardiff. In abortion, Tardiff (2015: 255-256) suggests,

"Achieving justice is difficult to define and mostly one sided: the mother lives on and the offspring dies. For just moral outcomes, two fundamental principles are often articulated: (1) permitting the maximized amount of basic liberty and (2) allowing inequalities in social primary goods only if they benefit all."

Rawl's (1993) theory of 'justice as fairness' describes a society of free citizens holding equal, basic rights and cooperating within an egalitarian economic system that does not overlook the disadvantaged. Under conditions of reasonable pluralism, the mechanism

by which he demonstrates this is called "overlapping consensus", similar to one of the tenets of democracy. Rawl's conception of justice comprises two main principles: liberty and equality (subdivided into Fair Equality of Opportunity and the Difference Principle. This 'diffusion up' theory regulates inequalities: it permits only inequalities that work to the advantage of the worst-off, like positive discrimination.)

Rawls chose the controversial subject of abortion to illustrate how values of political liberalism and public reason could be used to throw light on contemporary moral dilemmas (Shaw 2011). Although generally considered to be pro-abortion, Rawls argued against the moral status of the fetus as the primary determinant of policy – a position which Shaw disputes. Rawls (1993: 243) claimed,

"At this early stage of pregnancy, the political value of the equality of women is over-riding and this right is required to give it substance and force."

Conversely Rawl's ideal and non-ideal theories may be relevant to conscientious objection in their reference to compliance, coherence, and consensus. Ideal theory assumes that all actors (citizens or societies) are generally willing to comply with whatever principles are chosen. Ideal theory thus idealizes away the possibility of law-breaking, either by individuals (crime) or societies (aggressive war). It also ideal theory assumes reasonably favourable social conditions, wherein citizens and societies can abide by principles of political cooperation. Non-ideal theory follows on subsequently, for instance, once we find ideal principles for citizens who can be productive members of society over a complete life, we will be better able to frame non-ideal principles for providing health care to citizens with serious illnesses or disabilities (Wenar 2021).

Rawls reiterates the importance of 'reflective equilibrium', not unlike the striving for a harmonious balance of CO rights. His ideas about public reason and reasonableness relate most closely with ethical principles of justice but Rawls is not without criticism. For example, Quinn (1995) questions if a doctrine on which policy is founded without religion can be either reasonable or fair.

2.5.9 Autonomy

In earlier works, (Richards 1997: 164), it was maintained,

"The right to self-government and personal freedom is central to the idea of personhood and therefore to healthcare. This principle assumes that individuals have certain liberties

and are able to determine their own destiny (where to live, how to vote and which decisions to take about one's own body)."

The autonomy principle is drawn in part from natural law which is supported by the human possession of an intellect and instructs that killing another human is a moral violation (Little 2008). Basically, autonomy maintains that one oversees one's own thoughts, and one's own actions. As an ethical principle, autonomy is most often cited in discourse around abortion, because of the maxim 'bodily autonomy', namely the inviolability of the physical body. This emphasises the importance of personal agency, self-ownership, and self-determination of human beings over their own bodies.

Consider the following statement by Watson (2019: 1197)**:**

"When a woman does not see enduring pregnancy and delivering a child as a benefit, an autonomy analysis respects her as a moral agent who is following her values and allows her to decline the physical and social risks of childbearing."

Using the word 'moral' (which tends to be societally informed) here implies, however, that the woman exists in a microcosm, independent of other subjective influences. Perhaps if the term were to be substituted for 'ethical' or 'conscience-based', then one would gain a sense of the highly personalised and reflective nature of introspection, inward rather than outward-looking in abortion decision-making. Problems arise when values about abortion conflict: when enactment of the autonomous rights of the service-user stand in opposition with the rights of practitioners to their own freedom of conscience. The practice on the part of people in authority of restricting the freedom and responsibilities of those presumed to be subordinate to or otherwise dependent on them in their supposed interest, known as 'paternalism', is giving way to the autonomy of the patient as the main ethical idea which governs therapeutic relationships (Richards 1997: 164).

Informed consent is central to this idea of medical propriety: giving back control legally, medically, and ethically, to the patient, whose body belongs to them and whose person is thereby respected. In the words of John Stuart Mills' (1859: 21-22),

"Over his body-mind, the individual is sovereign."

It is assumed moreover, that the healthcare recipient is the best judge of decisions which concern them, largely because they (not us) live with the consequences. In the

success of any healthcare venture, their role is pivotal as opposed to co-operative. If empowerment is the ultimate goal, what is to be made of the conscientious objector, who opts not to undertake a functional responsibility as advocate and facilitator in abortion-seeking? The woman doesn't 'consent' to this (if guidance is followed, she should be neither disadvantaged, inconvenienced nor aware) which is where focus moves onto ethical codes and standards of professional behaviour.

2.5.10 Ethical Codes & Standards of Professional Behaviour

Pellegrino and Thomasma (1988) examine the principle of beneficence, addressing a wide array of practical and ethical concerns that are a part of health care decision-making relevant to abortion care and CO: competency assessment, the requirements for valid surrogate decision-making, quality-of-life determinations, the allocation of scarce health care resources, medical gatekeeping, and for-profit medicine. The authors argue for the restoration of beneficence (re-interpreted as 'beneficence-in-trust') to its place as the fundamental principle of medical ethics. Acting in the patients' best interests with a right and good healing action is only feasible if consonant with the patient's values. This worth is discerned by both practitioners <u>and</u> service-user in dialogue. To respect and honour their choice in the matter of treatment options is an imperative. Authors reject the long-held assumption that what is considered to be the medical good is necessarily the good for the patient less grounded in transparent decision-making and trustful relationships.

Codes of conduct, sometimes critiqued for a lack of flexibility, are useful to give voice to discussions surrounding ethics and provide guidance on equivocal dilemmas encountered in the workplace. As a guide for employees on how to act and behave, their value in preventing legal and regulatory violations is diminished, however, if it is used not as a blueprint, but as a punitive stick or a recipe.

The International Confederation of Midwives' (ICM) International Code of Ethics for Midwives (ICM 2024: 1) addresses the midwife's ethical mandates in keeping with the Mission, the international definition of the midwife, and standards of ICM to promote the health and well-being of women and newborns within their families and communities. The code states in the broadest of terms which encompass abortion care,

"Such care may encompass the reproductive life cycle of the woman from the pre-pregnancy stage right through to the menopause and to the end of life. These mandates include how midwives relate to others; how they practise midwifery; how they uphold

professional responsibilities and duties; and how they are to work to assure the integrity of the profession of midwifery.”

In the UK, this document is translated into the Nursing and Midwifery Council’s Code of Conduct (NMC 2021), structured around four themes – prioritise people, practise effectively, preserve safety and promote professionalism and trust. Throughout confidence in decisions and actions is the backbone on which professionalism is built. According to the NMC, this features behaviour, knowledge, excellence, integrity, and role-modelling.

The qualities valued in healthcare practitioners is not a new departure. To Aristotle moral values are the result of habitual adherence to them. They become second nature. Galen combined the innate nature and temperaments (Al-Bar and Chamsi-Pasha 2015). Trouble is, virtues are infinitely changing, may alter when widely applied in broad circumstances. Their interpretation and their application may depend on personal perspective and cultural norms. Widely considered to be a contemporary benchmark, however, is the founding work of Beauchamp and Childress, who have considered five virtues applicable to the medical practitioner: trustworthiness, integrity, discernment, compassion, and conscientiousness (Beauchamp and Childress 2013: 32–38).

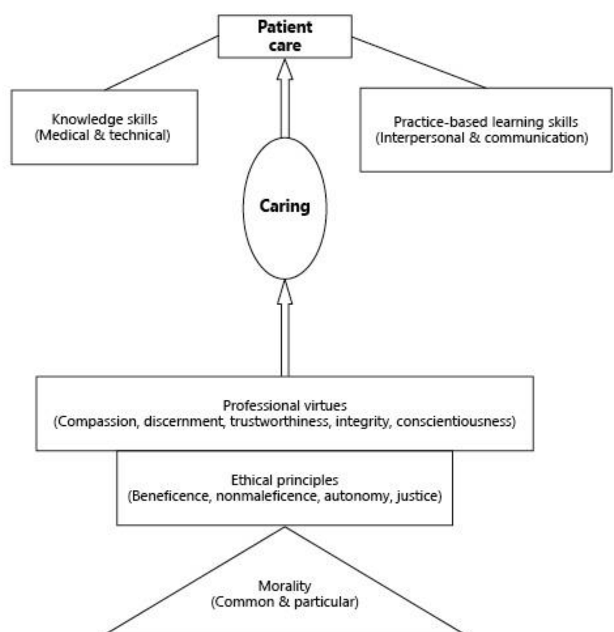
In keeping with virtue-based ethics, characteristics such as compassion, concern, caring, sympathy (sometimes empathy), patience and courage are amongst those widely expounded elsewhere in the literature (Al-Bar and Chamsi-Pasha 2015). Considering virtues in ethics increases the likelihood that “the emotional element of human experience” will be taken into account, which other theories do not (Gardiner 2003: 297).

An issue, mainly for the low-income countries, has been the extent to which ethical principles are considered universal or as culturally relative – the universalist versus the pluralist view (Avasthi et al. 2013). This has been one of the challenges: cultural sensitivity in a multitude of healthcare systems and a multiplicity of cases (Council for International Organisation of Medical Sciences 1993).

Where conflicts present, Varkey (2021) devised a model to use if ethical doctrines collide. The illustration demonstrates an integrated tool for application of ‘non-exclusive’ ethical principles, a flurry of professional values, cognitive and technical expertise to offer practical guidance, solving real life problems. Despite the oft incongruous needs of

individual cases, Varkey's conceptualised model frames the starting point and provides the building blocks for the virtue of caring, "one human to another".

Figure 6: Integrated Model of Patient Care (Varkey 2021: 26)



Predictive modelling is a highly cost-effective and personalised way of dealing with the complexities of everyday dilemmas. Despite criticism that the theorising can be too analytical, Varkey's model offers a conceptual starting point. Similarities in ethical behaviours, notwithstanding, may not be easy to detect or predict. Ethical dilemmas (poorly illustrated here) may yet well be at variance, in objection both across and within situations, changing over time and depending on circumstances.

2.5.11 Ethical Dilemmas

An ethical dilemma is a situation in which an individual needs to make a choice between two or more morally acceptable options that he or she can reasonably and morally justify or existence of a problem without a satisfactory resolution (Beauchamp and Childress 2013). Ethical dilemmas in SRH present more than any other sector.

For Mauron (2017) looking throughout history in a wider, global perspective, sex and reproduction have traditionally provided an important topic of ethical reflection, which in turn reflect prevailing beliefs about sexuality and reproduction, the place of women and children in society and facts of prenatal life as understood by different cultures in different times. Mauron (2017) argues that sexual and reproductive health rights entail three basic components: 1. Freedom to decide whether, when and how many children to

have; 2. Rights to modern family planning information and methods; 3. Rights to control one's own sexuality.

Dilemmas arise if these rights cannot be realised, or if these rights conflict with others' convergent liberties and freedoms.

Fry and Duffy (2001) trace the earliest, modern-day, ethical study back to 1935. They argue how changes in health care delivery have led to many more challenges though literature into the study of CO dilemmas specifically amongst midwives is scant in favour of ethical decision-making in nursing (Scanlon 1994). In Toro-Flores et al. (2017), the main CO of healthcare professionals in sexual and reproductive health was shown to be primarily to voluntary abortion, incurring a moral dilemma. Not only for the service-user, but for service provider, therefore, as much now as ever and as much at life's beginning as at its end, CO poses ethical dilemmas.

Assisted technology has brought with it a resurgence of dilemmas in sexual and reproductive health, which faces most frequent questions as a speciality dealing with the cusp of life (Schenker et al. 1997). This is because maternal-fetal medicine deals with two lives, both of whom should be viewed as a patient, according to Chervenak, McCullough and Brent (2011: 91). The nature of the obstetric dilemma, they state, is,

"Put more precisely, a human being without 'independent moral status' is properly regarded as a patient when two conditions are met: that a human being,

1. is presented to the physician and
2. there exist clinical interventions that are reliably expected to be efficacious, in that they are reliably expected to result in a greater balance of clinical benefits over harms for the human being in question."

This explains the fallacy of rights-based reductionism and two models of obstetric ethics based on it: the fetal rights reductionism model and the pregnant woman's rights reductionism model. This is highlighted in table 4 below:

Table 4: The Professional Responsibility Model of Obstetric Ethics (Chervenak, McCullough and Brent 2011: 315:e2)

Variable	**Fetal rights reductionism model**	**Professional responsibility model**	**Pregnant woman's rights reductionism model**
Pregnant woman	Pregnant woman's rights systematically secondary to fetal rights	Autonomy-based and beneficence obligations	Pregnant woman's rights systematically override fetal rights
Previable fetus	Fetal rights systematically override woman's rights	Beneficence-based obligations if the status of patienthood is determined by the pregnant woman	Fetal rights systematically secondary to woman's rights
Viable fetus	Fetal rights systematically override woman's rights	Beneficence-based obligations	Fetal rights systematically secondary to woman's rights

Conceptual and clinical failures of traditional diagnostic/biomedical models, disease-orientated and hospital based, mean they should be abandoned, authors argue. They favour a move to a more ‘professional responsibility model of midwifery ethics’, which emphasises the importance of compassionate clinical care of both the pregnant and fetal patient. The hoped for result is that responsible midwifery care overrides the extremes of clashing rights. Nonetheless the model does not quantify viability, currently set at a legal limit of 24 weeks, but morally lesser gestations may be viewed differently depending on the concept of when life begins. More recent works (McCullough et al.

2019: 24) concentrate on advice to foster ethical decision-making, ‘by, with and for patients’ based on their recommended model which renders clearer the blurred lines.

Megregian et al. (2020) highlighted the kinds of ethical dilemmas contemporary under-graduates face in conflict with abortion services. Challenges related to complex medical conditions and/or social circumstances, to protecting or promoting autonomy/informed consent for women and strained inter-professional relationships. Midwives also discussed the difficulty women experienced in accessing appropriate care, particularly in rural areas who may be seeking genetic screening or abortion care, who may require perinatal care outside of the midwives’ scope of practice, or who may seek interventions that are contrary to midwives’ recommendations (Megregian et al. 2020: 522). Themes centred on definition of ethical dilemmas: unease; unease around uncertainty of action; unease in compromise of action; unease in reflecting on action which together seem to suggest not only philosophical/theoretical aspects but also how these transfer into practice. Authors suggest an element of ‘on the job experience’ in addition to formal programmes of education. Megregian et al. (2020) offer a current frame of reference, analysing ethical dilemmas, and the mechanisms of moral reasoning, which may be partially replicated.

2.5.12 Moral Reasoning, Choices, and Ethical Decision-making

Despite wide recognition of Beauchamp and Childress’ four principles approach to ethics, it is not without its critique. Rather more than a set of ordered rules, like a computer which will pop out a set of answers at the press of a button, Gillon (1994) advises instead devising one’s own moral language. The four ‘prima facie’ principles approach (meaning the ethical principle is binding unless it conflicts with another moral principle) is criticised as an algorithm incurring “dissatisfaction” by Gillon (1994: 187). Using the common framework (autonomy, beneficence, non-maleficence, and justice) ‘plus scope’, he suggests commits ourselves to reflective concerns, so whatever ethical decision is made is contextualised. Based on organisational policy, societal norms expressed in law and practice or my profession’s stance, Gillon (1994: **187**) asserts,

“I have no special privilege as a health care worker, however, to create societal rights for my patients.... if I believe that the law is morally unjustified, I am morally entitled to break the law, but this gives me no legal entitlement to break the law, and I should be prepared to face the legal consequences of disobeying it.”

Gillon goes on the paint a picture of personal decision-making that involves excluding pursuit of self-interest, discrimination, choices without a moral basis or justification, wasted resources ('distributive justice') affording patients' rights and moral acceptance. In ensuring 'to whom the duty of care is owed' or narrowing down to whom we have a moral obligation, the nature of scope is substantiated. Boundaries exist (a duty of care not to everyone in the world, present and future, or every living creature). He opposes the *Socratic gadfly* (disparate moral cultures sharing a common moral commitment). For Gillon, autonomy is the principle which 'trumps the rest'.

Page (2012) attempts to measure and compare them. In an attempt to gauge ethicality, she considers situational factors and makes the model more behavioural. Critics say the practice of making judgment are often left out of the equation. 'The Analytical Hierarchy Process' (AHP) she devised makes sense of priorities and takes account of pragmatic, subjective preferences between the four principles. Gillon's (1994: 308) description of these as "moral nucleotides that constitute moral DNA": is a metaphor which invokes reasoning as part of our internal make up, life's blueprint and essential to our moral functioning. Page (2012: 6) thus "reweights" (2012: 6) these with situational factors. Like this thesis, Page concludes that although people state they value ethical principles, their abstract, philosophical bias limits practical application. Page recommends the use of a behavioural model "explaining cognitive use of the principles in decision-making", which is why Varkey's (2021) is so relevant and valid.

Velasquez et al. (2015: iie) outline an alternative approach which suggests a five-fold analysis (using conventional Utilitarian, rights-driven, fairness/justice, common good and virtue-based approaches), followed by asking five pertinent questions:

1. What benefits and what harms will each course of action produce, and which alternative will lead to the best overall consequences?
2. What moral rights do the affected parties have, and which course of action best respects those rights?
3. Which course of action treats everyone the same, except where there is a morally justifiable reason not to, and does not show favouritism or discrimination?
4. Which course of action advances the common good?
5. Which course of action develops moral virtues?

Critics may suggest the formulaic checklist offers little concrete solution, posing more questions than it solves, but it is not designed to. The theory's strength lies in its

flexibility. It is designed to be a reflective tool, that facilitates insight, teaching aspiring ethicists how to fish for themselves, rather than proffer for them an easy answer on a plate. The nature of dilemmas guarantees there is no such convenience. There is never 100% certainty. All decisions are subject to bias and conflict.

Midwives are required as part of mandatory multi-professional training requirements to reflect on human factors and communication in relation to obstetrics. Part of the 'Safe Maternity Teams' initiative calls upon practitioners to reflect on techniques of decision-making, citing the work of psychologists, like Kahneman, whose book 'Thinking, Fast and Slow' was published in 2011. His main idea relates to a differentiation between two modes of thought: "System 1" is fast, instinctive and subject to emotion; "System 2" is slower, more deliberative, and more logical. Kahneman's theory can be compared equally to 'CO crises' calling for insight and ingenuity. For instance, whether the situation is a life-threatening emergency, or a more considered conscientious objection. There are traces of this kind of thinking in the data. In the clinicians' model (Safer Teams 2019) instruction suggests it is worth considering different techniques on how decisions are made, depending on the circumstances surrounding the decision, how feasible are the options, the setting and the level of support or resources. For instance, this also may be influential in CO crises when an objection may be pressured by colleagues, or indeed supported.

For example, analytical (or choice) decision-making relates to those situations when options are generated and compared, so can be slow. One example of this form of decision-making relates to pre-understandings in abortion and the stance on freedom of conscience, although not necessarily set.

Whilst 'gut reactions' under stress may be the best intuitive response to solve the immediate problem, it may not always be in the best moral interests of the objector, or any other stakeholder. Distractions, like noise, disturbances, interactions and so on, may interfere with these ethical decision-making skills, much like any other. By their very nature, dilemmas are those decisions less easy to justify or clear where the benefit rests.

Creativity is especially important if a situation has never been or rarely, encountered before. Situational assessment may thus apply rules-based behavioural models, or procedures to evidence the most appropriate outcomes. This requires more cognitive thought and guides the decision-making, especially for novices. An example of this might be the Abortion Act and conscience clause, which will now be examined.

2.6 Theme 5 - Two Signatures and The Escape Clause

2.6.1 Rights to Freedom of Conscience

Rights to freedom of conscience are enshrined in Article 18 of the United Nations Universal Declaration of Human Rights (UN 1948),

"Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance."

In the UK, this pledge is reinforced in the 1998 Human Rights Act.

Specifically related to the criteria on which abortion is legally permitted, clause 4 (section i) of the Abortion Act 1967 was designed by legislators to recognise the manifest rights not to participate in acts which contravene this 'religion or belief in teaching, practice, worship and observance.' More closely defined in 4 (2), the so-called 'conscience clause' states,

"No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection: Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it."

For all that the 1967 Abortion Act was heralded as a breakthrough where the debate on conscience clauses has gone "astray" is in the burgeoning focus solely on religious motivation and secular moral beliefs, to the exclusion of conscience (Fernandez-Lynch 2008: 33-34). Refusals grounded in values are infinitely subjective and laden with value-judgments. A third of US conscience clauses fail to state what constitutes acceptable grounds, so progress is clouded.

Article 18 links to other aspects of the declaration which freedom of conscience objectors may draw on – principally in terms of rights to life, equality, liberty, and freedom of expression. Of course, these rights are drawn upon as staunchly by advocates of either persuasion. Various articles may stand in tense juxtaposition with each other and nowhere is the sense of acrimony felt more acutely than in CO to abortion, increasingly polarised and political.

Article 9 (1) of EU Convention on Human Rights expresses the ethical principle of autonomy, but how this equates to the involvement of others is central to freedom of conscience. The World Health Organisation (WHO) (2012: 91) states,

“While the right to freedom of thought, conscience and religion is protected by international human rights law, international human rights law also stipulates that freedom to manifest one's religion and beliefs might be subject to limitations necessary to protect the fundamental human rights of others.”

In essence, accommodation of CO balances these two poles.

Zaami et al. (2021: 350) examine the implications of two recent European Court of Human Rights (ECrHR) cases *(Grimark vs. Sweden; Steen vs. Sweden)*. More should be done to facilitate the midwives’ accommodation, argued Grimark and Steen, who had exhausted local labour tribunals before calling for an EU ruling,

“Ultimately, CO in health care, and how to strike a tenable balance between the rights of objecting professionals and those of patients seeking care or the prescription of medication, are daunting challenges with legal, ethical and social ramifications of enormous magnitude.”

In a decision which supported Swedish authorities, judges concluded that the right to reproductive health, including abortion outweighed freedom of conscience. The midwives had voluntarily undertaken their chosen career and applied for substantive posts in the knowledge of the requirements of their employers and indeed, of the Swedish constitution, which guarantees like other EU member states, universal access to healthcare. The case highlights difficulties in traversing the fine line of acceptability in legislature for all member states and for multi-disciplinary teams, in CO, which is fast-moving, variable and open to interpretation (Zaami et al. 2021). Whether the economies of scale afforded by multi-lateral bodies is effective in meeting the needs of individual practitioners is outside of the remit of this thesis, suffice to say, the use of precedent needs to be sensitive enough to respond to changing healthcare needs, time-bound for women, without inconsistencies. To this end, WHO guidance urges the elimination of third-party authorisation requirements, regulating policy and access barriers (WHO 2012: 98) that,

“Interfere with women and adolescents’ rights to make decisions about reproduction and control over their bodies.”

In appreciating why those access barriers occur, this thesis aims to frame greater understanding of accommodation. By exploring the moral reasoning of practitioners, never previously undertaken, it will provide less equivocal strategies for dealing with the situational dilemmas of CO. How to strike this harmonious balance, therefore, will be examined in the final theme ‘The Right Midwife Delivering the Right Care’, which will discuss what comprises the ethically sound practice, care in CO terms, and how best to achieve an accessible and available care, delivered by whom, accommodating CO.

2.7 Theme 6 - The Right Midwife Delivering the Right Care

2.7.0 Duty of Care

According to the RCN (2023),

“Duty of care' refers to the obligations placed on people to act towards others in a certain way, in accordance with certain standards. The term can have a different meaning depending on the legal context in which it is being used.”

In conscientious objection, it can be assumed that situations may arise where it is “reasonably foreseeable” that potential harm can be caused so a legal duty of care is imposed on practitioners. Despite the medico-legal provisos, abortion care is no different in this duty to any other aspect of healthcare. In accepting professional commitments, the qualified midwife has been assessed to have obtained standards expected of an 'ordinarily competent practitioner' performing that particular task or role. Generally, the statutory body advises that failure to discharge the duty to this standard may be regarded as negligence and may be prosecuted as such. The RCN supports that when harm has come to a patient, the law examines who has a duty of care to that patient - and whether there was negligence - in order to attribute responsibility/liability for that harm.

In cases where the midwife may hold an objection, (which is, remember, likewise supported by law), the professional duty of care is not entirely disregarded. The potential to negate the impact of care by freedom of conscience expression is described elsewhere in the thesis by Neal (2019) and termed as “sanctions of abandonment” by Dickens (2021: 556) (see pg. 251). Berlinger (2008: 35) acknowledges the potential for a situation where CO goes too far,

“At what point does refusal to consent constitute medical neglect? At what point does a clinician’s moral objection to providing treatment interfere with a patient’s access to treatment and violate ethical standards?”

Holding practitioners to account,

“If a registrant fails to discharge their professional duty of care (i.e. by breaching the Code and related standards) they may be referred to the NMC under the NMC’s Fitness to Practise procedures.”

Seeing no harm done by their objection, therefore, involves practitioners ensuring just and proper, life-supporting care as well as abstaining from actions which may impair access and availability to abortion provision, also legally endorsed as a human right. They may opt not undertake a proactive role in participating in abortion – but still are obliged to display a neutral stance in their contact with service-users when abstaining.

Duties are not always clear cut, however. In sexual and reproductive health, midwives’ duties could be argued to extend wider than to the woman – should the midwife’s norms and values be reflected onto the unborn child, his/her employer/the institution, the profession, or society/the community at large?

In this regard, Cantens (2019: 7) asserts care is a right, not a privilege or a gift. Their work distinguishes between several types of duties which may help establish priorities,

- Absolute Duty – performed without exception, *always* telling the truth.
- Prima facie – with an obligation but not in all circumstances, depending on the situation (similar to Kant’s *Categorical Imperative).*
- Universal – which persist through time and transcend different cultures and contexts, apply to all people.
- Contextual – moral obligations that arise out of particular circumstances, depending on our understanding of them.

Primarily it is the midwife’s ‘absolute’ duty of care which is reflected in her professional midwifery obligations but to undertake a role in abortion services, following Kant’s Categorical Imperative, then this ‘prima facie’ duty would be more in keeping with the above definition. Fox (2012) outlined key themes in health and social care surrounding ways in which ‘The Body’ and its associated identities are viewed, as a social, desired, caring, managed or technological assemblage, for instance. Most relevant to this discussion are

his ideas relating to embodiment in health and illness and social responses to it. Thinking more than biologically, he discusses the mutual but professionalised relationship between carer and recipient. The focus will now turn to professional matters, identifying expectations of 'the right midwife'.

2.7.1 Understanding Consent

Information–sharing and interactions between professional and service-user feature very much as part of the focus on applying informed consent in the author's previous work. Richards (1997) reasserts the responsibility of the midwife within therapeutic relationships to be an effective communicator, facilitator and advocate which underpins all midwifery practice. Abortion-seeking assigns a role for the healthcare professional, for example, signposting to ensure that the individual knows what options available, and gain insight into what they are consenting to.

The WHO Guideline "Safe Abortion Technical and Policy Guidance for Health Systems", (2012: 97), refers to effective communication and honest (presumably impartial) information-sharing as a key influence with bearing on decision-making,

"Censoring, with holding or intentionally misrepresenting information about abortion services can result in a lack of access to services or delays which increase health risks for women. Provision of information is an essential part of good quality abortion services."

To act as facilitator and gatekeeper for the service-user transitioning into the abortion service – is a very privileged position but realising healthcare rights is still by permission. Tingle (2017) makes interesting comparisons to a case of a Jehovah's Witness who did not give consent to a blood transfusion. A competent adult patient has an absolute right to accept or refuse medical treatment even if the doctor, nurse, or relatives disagree, think that decision is unwise and this could lead to the death of the patient, Tingle maintains. Some of the participants in this study allude to the same analogy. Tingle says this issue was put very clearly by Mr Justice Mostyn in the case of Nottinghamshire Healthcare NHS Trust and RC [2014] EWCOP 1317 (the Nottingham case) when he stated:

'In principle, every citizen who is of age and of sound mind has the right to harm or (since 1961) to kill himself. This is an expression of the principle of the purpose of power

found in the Declaration of the Rights of Man and of the Citizen (1793) and in John Start Mill's essay "On Liberty" (1859).' Paragraph 8 (cited by Tingle 2017: 118)

The title of his article is 'Patient Consent and Conscientious Objection', is perhaps misleading conceptually. This type of objection more rightly may be known as 'treatment refusal' but still the point is made that in recognising a commitment to relational autonomy, the balance of power shifts. In the relationship between two conceding parties, at what point is this granted? Does the midwife accept responsibility for care or is the duty of care a given that cannot be invoked? If consent can be given, it can be presumably taken away by both parties and therefore what precedent this sets for others needs to be discussed with whatever implications for the community at large. How midwives decide to withdraw their professional services is the focus of this thesis.

2.7.2 Advocacy and Role Conflict

Where the scope of practice ends in conscientious objection is blurred for midwives, whose daily endeavours focus on empowerment, advocacy, and nurturing pregnancies. Some question if an objector is truly best placed to provide that package of care which entails emotional support and affords an opportunity to rationalise decisions if requested. One might dispute if an objecting midwife can truly be a representative of the patient's well being, if their interests and agendas are so very incongruent. How to realise reproductive justice, or help the service-user exercise their choices, whilst seeing no harm done, is also key.

In balancing vested interests of individual patient versus society and how these can best be represented, Wicclair (2011: 64) cites the work of Fry and Johnstone (2008) who apply the concept of advocacy to nursing (not midwifery, note):

1. Patient Rights Protection Model – nurses advocate for patients defending their healthcare rights.
2. Values-based Decision Model – pertains to the nurses' role in facilitating informed decision-making by patients, viewing the nurse as a professional who helps the patient discuss his or her needs without imposing values on the patient's choices.
3. Respect for Persons Model – views the patient as a fellow human being with equal entitlement to respect.

Fry and Johnstone's (2008) citation is an exception to the rule of using secondary sources. Wicclair's take on how the conception of advocacy fits in with his own ideas is interesting. For example, conscience absolutism is not compatible with a patient rights-based model, Wicclair suggests, whereas his theory of accommodation fits more within a respect for persons model.

The phenomenon which arises when an individual's personal values, beliefs, or interests conflict with their role's expectations is known as 'person-role conflict'. Conflict can be, of course, detrimental to therapeutic relations, contravening what care means. The types of "Janus choices" (Sulmasy 2018: 5) made in conscientious objection epitomise the kinds of competing demands made on an individual. Later we will look at Sulmasy's (2018) work and the kind of violation in commitments freedom of conscience raises (see pg.75). The point of the framework of moral reasoning (detailed in Table 8 on pg. 253) is to better grasp how these conflicts are rationalised and provide evidence for a more systematic approach in order to resolve these conflicts.

2.7.3 Paternalism and How Empowerment Overcomes It

In section 2.5.9 (see pg. 98) on autonomy we looked at bodily propriety in relation to sovereignty. Let us recap on autonomy and remind ourselves how paternalism may restrict autonomy. Whether in terms of laws and regulations (state) or individual acts (personal) paternalism is problematic in healthcare because it prompts the questions – how far/to what extent, by whom and to whom is autonomy relinquished. In denial of freedoms, paternalism violates moral rules but more so practically, is open to coercion, control, manipulation, and interference (Andre and Velasquez 1991).

Pecorini (2002) suggests paternalism may only be justified for four main reasons,

1. Harm principle: to stop an individual causing harm to others.
2. Paternalism principle: to stop a person from self-harm (weak) or to benefit a person (strong).
3. Legal moralism principle: legislated morality to prevent harm to improve situations.
4. Welfare/Social benefit principle: for the benefit of all (or many).

Considering paternalism is relevant to this thesis because it highlights the mechanisms of decision-making (not solely in one person's domain) and invokes a sense of disempowerment when others take charge.

In terms of the midwives' role, the Expert Maternity Group in Changing Childbirth describe the professional as a facilitator of choice as far back as 1993. The message is reiterated in Better Births, the National Maternity Review (NHS England 2015: 4). In keeping with the theme of personalised care and safety,

”Women have made it abundantly clear to us that they want to be in control of their care in partnership."

Assumptions associated with autonomy are that the woman has 'competency' and 'decisional capacity'. Remembering that pregnant women are not generally speaking incapacitated and pregnancy itself is not viewed as a disease, it follows that pregnant women are best placed to know their own mind and make health choices about care that foremost affects them. However, if one is, as the grounds of the Abortion Act stipulate, going to claim impairment of health because of an unwanted pregnancy, should the ensuing status be seen to impinge judgment? a paternalist might claim.

In moving away from paternalistic attitudes, twentieth-century universal suffrage, enfranchisement and good governance were brought to the UK ballot box by war, ever the impetus for politicization and catalytic social change. The focus of this thesis strictly speaking is not about the rise of feminism, but suffice to say, gender will be considered for its influence insofar as it relates to empowerment. Since the sixties - in a very Foucauldian pedagogic shift (Fahy 2002) - empowerment has been "increasingly used in the midwifery context to strengthen the woman and her family" (Hermansson and Mårtensson 2011: 811). According to one of the statements in the code of ethics for midwives,

"Midwives work with women, supporting their rights to participate actively in decisions about their care and empowering women to speak for themselves on issues affecting their own and their families' health within their culture/society." (ICM 2024: 1)

Empowerment is at the heart of policy on gender equality, mentioned in sustainable development goal 5 (Baghini et al. 2023). Sharing decision-making, sharing knowledge, sharing power liberates service-users from submission and oppression to reach a more Egalitarian, co-operative status. This is just one of many psychological characteristics, the most important of which is having the opportunity and possibility to make autonomous decisions.

Needless to say, dramatic variance exists in achieving this goal between marginalised communities. Policies may be directed to accentuate empowerment in the workplace or domestic situation. In addition to beliefs, educational, socio-economic, political, cultural, gender-related issues may all impact on the ease and effectiveness of policy measures implemented. The starting point in that is access to abortion/family planning, and control over one's fertility many commentators argue strongly. For example, in a mixed method study conducted in Nepal, Heera et al. (2021: 4) conclude, empowerment enables women to,

"Exercise free choices, (*the)* right to control fertility, right to take an autonomous decision on healthcare seeking behaviour, mobility, reproductive rights, ownership of assets, participation in social group and increases awareness."

In the home, marital status is a crucial component of couples' decision-making rather than women's only contraceptive decisions (Hameed et al.2014). The flipside of empowerment in conscientious objection is that it moves towards comparable empowerment, of a third party in abortion decision making. The emotional distress experienced by midwives above all else centres on this dilemma: that their non-participation contravenes the principles of empowerment. Opponents of conscientious objection advocate that control over one's fertility represents a right that nobody should be able to interfere in – the pivotal power over when and how many children to bear.

2.7.4 Emotional Labour and Moral Work in Ethical Decision-making

Hochschild (2003) suggests emotional labour refers to regulating or managing emotional expressions with others as part of one's professional work role. She explains that emotional labour is about attempting to feel the right feeling for the job, prototypically 'service with a smile'. Ultimately, Hochschild offers us a way of seeing and understanding feelings as part of the presentation of self. In the book 'The Managed Heart: the Commercialisation of Human Feeling', Hochschild tells us that the way feelings are managed is a bit different than other self cues - it involves deep acting, self-induced feelings, and their emotional responses. Hochschild illustrated her theory of how social situations influence emotions by highlighting the experiences of occupational groups as disparate as flight attendants and bill collectors. Jobs requiring emotional labour are identified as possessing three dimensions:

- they require face-to-face or voice-to-voice contact with the public.
- they require the worker to produce an emotional state in another person.

- they allow employers via training and supervision a degree of control over the emotional activities of employees.

To manage emotions socially, we exhort ourselves, we induce emotion through imagining emotional memories, and we use personal props, Hochschild maintained. With elements of being less than true to oneself or 'faking' ones values, the effort of emotional labour, like physical labour, can have detrimental and negative consequences. Performance errors and job burnout can occur especially when 'surface acting', because it results from feeling inauthentic. This has strong implications for carer, the carers and those cared for.

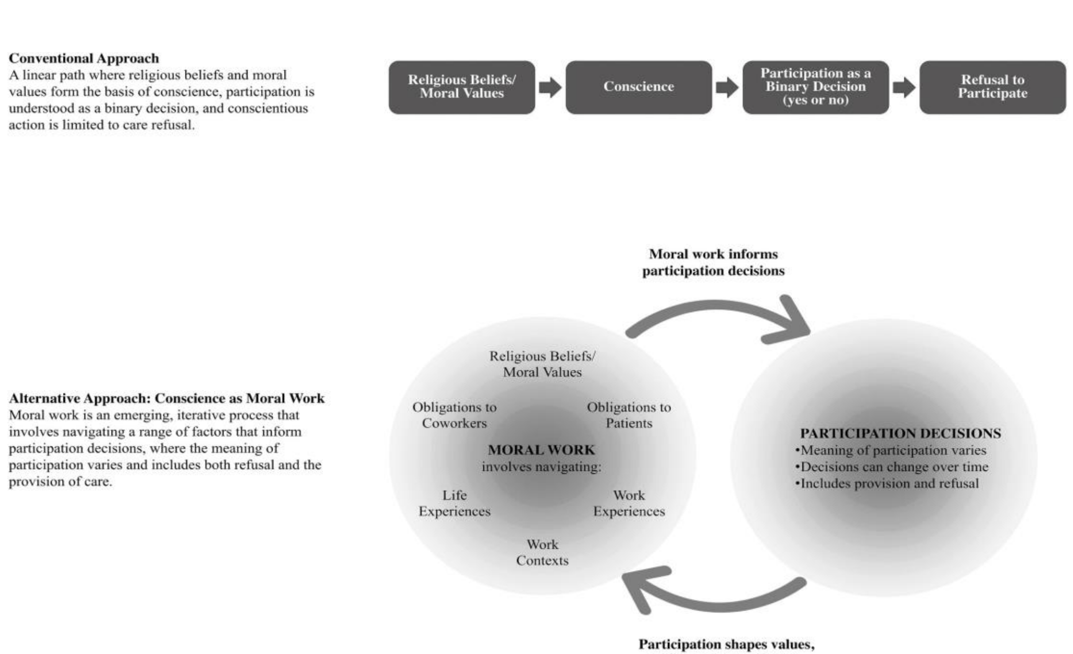
The literature links the phenomenon of emotional labour to practitioners in health (Celik et al. 2010; Riley and Weiss 2016). Theodosius (2008) also examines emotional labour specific to nursing. As essentially a social and communicative profession, Theodosius questioned 'Do nurses still care?' In today's inflexible, fast-paced, and more accountable workplace where biomedical and clinical models dominate health care practice, understanding the sociological notion itself is key. Fundamentally interactive and communicative, Theodosius argues that emotional labour is intrinsically linked to personal and social identity. The nursing profession has a responsibility to include emotional labour within personal and professional development strategies to ensure the care needs of the vulnerable are met, they recommend.

More critically, this alludes to abortion provision not dissimilarly to those described by Boama (2018) in 'The Abortion Doctor'. Very much a lived experience of these participants, the dilemmas reflected in freedom of conscience, pertain trace elements of emotional labour. When midwives morally reason, they are conscious of their public role, their obligations, and professional commitments yet they are mindful of how objection is perceived. The resulting ill ease prompts them to compartmentalise their beliefs and feelings, in a Pandora type box, midwives in this study tell us. The kind of modifying inner emotion Hochschild alludes is referred to in data as a personal and professional persona.

Mindfulness techniques can help stress management, as can team collaboration. Putting employees first, not customers is one way suggested in the literature for managers to deal with the crisis of confidence that is emotional labour. Giving employees autonomy and support is key: allowing them the freedom to take a break if

needed, or to decide how to manage emotions, and supporting the employee. Similar recommendations are made in this thesis, supporting midwives, supporting service-users. The conceptual model devised by Czarnecki et al. (2019) on ‘moral work’ pays more attention to decision-making mechanisms. It shows conscience as an emerging, iterative process influenced also by personal experience in social and institutional contexts. Whereas most research focuses on whether healthcare workers should be required to provide care that maybe violates their conscience, Czarnecki et al.’s work explores how, which is equally complex. Czarnecki’s conceptual model, grounded in lived experience, contrasts with conventional approaches to conscience and emphasises the need to examine a wider range of factors that present.

Figure 7: Model of Conventional and Alternative Approaches to Conscience and Participation in Abortion Care (Czarnecki et al. 2019: 187)



Influences such as personal and work experience as well as obligations to co-workers and patients shape people's decisions beyond the religious and moral values about abortion. The illustration shows participation decisions can change over time as engaging in moral work can alter one's perspective and views metamorphose. The sense and meaning making aspects of this model by Czarnecki et al. render it synced to Hermeneutic thinking where research philosophy focuses on a cyclical process of learning about a phenomenon.

Using models to analyse particularly qualitative research findings is not new. Each theorist brings a framework reflecting principles of phenomena they have noted: one

way to best illustrate key factors, highlight recurring themes, flag up contrasts and aid comprehension. The point about *ethical* decision making however, is highly individualised and infinitely subjective so the application of scientific rules proves inherently problematic. Some attempts have been made to analyse the process and reflect on it being systematic in design.

2.7.5 Links to Models of Maternal Mortality

According to the WHO (2004: 87), unsafe abortion accounts for one in four of the main causes of maternal mortality and morbidity worldwide. WHO (2012: 90) later goes on to develop this idea, that,

"Evidence increasingly shows that, where abortion is legal on broad socioeconomic grounds and on a woman's request, and where safe services are accessible, both unsafe abortion and abortion-related mortality and morbidity are reduced".

In establishing why women die? for example, Thaddeus and Maine (1994) devised similarly a model – of "Three Delays" adopted by the World Health Organisation. It proposes that pregnancy – related mortality is overwhelmingly due to three main causes or delays:

1. In deciding to seek appropriate medical help for an obstetric emergency
2. In reaching an appropriate obstetric facility
3. Receiving adequate care when a facility is reached

The dangers of restrictive laws and policies can cause delays especially in health – seeking behaviour. "Complex and burdensome administrative procedures" (WHO 2004: 542) were highlighted as contributing factors in the case studies of several maternal deaths and warnings are provided against precisely those kinds of infringements of civil liberties and human rights. In a broad overview relative to moral reasoning in dilemmas, Harris et al. (2016: 1) state,

"CO can act like a barrier to abortion access – impinging on reproductive rights and increasing unsafe abortion and related morbidity and mortality."

WHO (2012: 87) comment,

"Additional barriers, that may or may not be codified in law, often impede women from reaching the services for which they are eligible and contribute to unsafe abortion."

These barriers suggest WHO, are complex and can have fatal consequences, justification indeed for a legal, open, transparent, and safe system of CO. A compromise which balances a pregnant woman's obligation to her unborn child ((in)voluntarily assumed, in Jarvis-Thomson's argument) with expected ''sympathetic responses, if not agreement, from other professionals" (Wicclair 2011: 7) would save lives.

2.7.6 Working Rights or Obligations? The Role of Statutory Bodies

According to the Nursing and Midwifery Council (NMC 2021, para 4.4), the statutory right of CO to abortion for nurses, midwives and nursing associates is addressed in two areas:

a) Section 4 (1) of the Abortion Act 1967 (Scotland, England, and Wales)
b) Section 38 of the Human and Fertilisation and Embryology Act (1990)

One of the most recent legal tests of provision is the Supreme Court decision in the case of Greater Glasgow Health Board (Appellant) vs. Doogan and another (respondent) (Scotland) (2014). This legal precedent provides additional information on the meaning of *participation* in any treatment (detailed in the introduction). Harmon (2016: 143) describes the case as a "missed opportunity for an instructive rights-based analysis", which he states,

"Failed to engage holistically with the foundation of conscientious objection and its position relative to the competing right to adequate healthcare, a failure which must be seen as a lost opportunity given the manifold threats to timely access to abortion."

Furthermore, the BMA (2018b) highlights the case of Janaway vs Salford HA which not only reiterated the idea of participation but reasserted the dictate that conscientious objection is limited to those *who take part in* procedures in hospitals or approved clinics. In Janaway's case, a doctor's secretary could not conscientiously object to typing a referral letter for abortion services, which may be viewed by some as being a quite literal 11/10ths interpretation of Canon law. To quote the BMA (2018b: 11),

"There may be some tasks that fall outside the legal scope of the conscience clause but morally within it."

Like the Royal College of Midwives, the BMA (2019b) supports removal of criminal sanctions for abortion. In a stance taken also by this thesis, the BMA supports the following principles:

2.7.7 BMA (2019b) Position Paper

1. Abortion must only be permitted in cases where the woman gives informed consent, or in cases where the woman lacks capacity, and an abortion is determined to be in her best interests.

2. Health professionals must have a statutory right to conscientiously object to participating in abortion.

3. There should be a central collection of abortion data (subject to agreed appropriate confidentiality protections) to ensure future services are fit for purpose.

4. There must be clarity about what is, and what is not, lawfully permitted, so that health professionals are clear about the scope of their clinical discretion.

5. There should be robust clinical governance in settings where abortion care is provided.

6. There should be the continuation of some degree of regulation and the setting of professional standards in the provision of abortion services.

To this end, recent consideration of CO in the 2018 parliamentary Bill are described by Bruce (2018) as "timely and welcome."

Medico-legal aspects link very closely with the ethical principle of justice – seeing no unfair treatment and respecting everyone's rights as equal, fair, and impartial. Hewson's (2001: ii10) look at reproductive autonomy and the ethics of abortion suggests, quite controversially, that,

"If everyone could be compelled by law to do what others considered "right", we should have no freedom, only moral dictatorship."

In the same way as medics, lawyers are often instructed to do things that would strike others as immoral and contrary to doctrine or reason. As a professional, one is not expected to pass judgment on the client: the so – called "cab rank rule" – which obliges barristers to accept instructions regardless of the client's case. Furthermore, Miola (2015a; 2015b) discusses the cross over the idiosyncratic nature of ethical decision-making and participation,

“Whether to perform an abortion is not a clinical decision for which doctors have a unique competence – how to perform that abortion is”.

Jurist Ramon-Cossio, quoted in Fiala et al. (2017) warns against unchecked what he calls, “absolutism of conscience”. He suggests that compounded by uncertainty which obstructs the rights of others, restrictive abortion laws infringe the rights to privacy, equality and autonomy of the woman. Ramon – Cossio states,

“While legislation recognises these to mean, so there are grounds for thinking that these laws are discriminatory”.

Ana Maria Acevedo was one victim who paid the ultimate price of flawed absolutist traditions, ill transparent decision-making and a poorly defined CO system designed mostly by men (see Appendix 11). The injustices of the case study featured have proved the rallying cry for the Argentinian women’s movement characterised by the wearing of green scarves, in Spanish: pañuelo verde – the symbol of the politicisation of abortion rights. The slogan perhaps sums up the call for action best. Roughly translated it means "Sex education to decide, contraceptives to avoid abortion, legal abortion to avoid death".

This argument leads Hewson (2001: ii) to conclude, in the same way as this review,

“So, what can a barrister say on the ethics of abortion? Is there a new ethic developing? Should there be?”,

A new ethic may consider viability, asking if life starts at conception, and may take into account the significance of gestation, in legal terms when life begins. This makes certain abortions more troubling, for example, those later, those recurrent and those undertaken for certain reasons.

Asserting the primacy of patient interests, the BMA (2018a) acknowledges that there may be some situations in which staff are challenged to provide, “clinically indicated care in a supportive and non-judgmental manner, procedures that are nonetheless lawful” but which may not sit comfortably with their moral or religious position. Apparently, the General Medical Council deals with an increasing number of requests from doctors for intervention and in accordance with NHS constitution remains committed to provision based on need. However, accessible, and equitable the UK healthcare service may endeavour to be, the paradox remains that patients take

precedence in cases of conscientious objection. With reference to the primacy of the service-user above service provider, the BMA (2018a: 2) states,

"Where conflicts arise, between the interests of the patients and a professional's freedom to exercise his/her CO or to manifest belief, in the BMA's view, they should be resolved in favour of the patients."

The Royal College of Nursing (2019) leads the way with the clarity of its guidance and its July 2019 update of the 2003 Human Fertilisation and Embryology Authority (HFEA) Code of Practice provides the most current insight into freedom of conscience issues. In terms of the Scottish test of "participation", the RCN (2019) delineates that CO rights are "limited" to the termination procedure only and not to care provided before and/or after the procedure is carried out. At the beginning, the guidance boldly announces,

"Legislation recognises that healthcare workers may have religious, moral or personal objections to abortion."

This statement is key to our understanding in defending rights as part of statute – which means individuals cannot be prosecuted for CO. Determining to what extent individuals are held to account for implementing policy, not least if the policy is incongruent with their own beliefs, faith and opinions is still disputed, however. As the RCN (2019: 262) points out, the newest (8th) HFEA Code more recently discusses treating people fairly. Guidance, (which incidentally refers to regional disparities), spells out that,

"No person who has a CO to participating in any activity governed by this Act shall be under any duty, however, arising from doing so. In any legal proceedings, the burden of proof of CO shall rest on the person claiming to rely on it. In any proceedings, before a court in Scotland, a statement of oath by any person to the effect that he has a CO to participating in a particular activity governed by the Act shall be sufficient evidence of the fact for the purpose of discharging the burden of proof imposed by sub-section (2) above."

2.7.8 Adjudication and Tribunals

In terms of adjudication of this duty and accountability, tribunals are mentioned in the literature (Card 2016), but the verdict is still out on their usefulness and validity. The main advantage is put forward quite persuasively that conference allows an opportunity to examine CO in an open forum, to address critics' cynicism over motivation: overall, to

determine the genuineness and reasonableness of each freedom of conscience decision (Hughes 2015).

Cowley (2016) provides a converse view, also convincing: that tribunals may be expensive, inconsistent, and difficult to administer. Cowley also offers a warning that distinguishing between cases could lead to “cherry–picking”. Based on a model of military conscription, Cowley argues, tribunals lead to more, not less arbitration. What is more, the risk of false positives leads him to defend the status quo, where healthcare professionals are not formally required to defend their beliefs. No–one is forced to become a healthcare professional, asserts Cowley and many may share the similar view: that midwives are not forced to take up employment in abortion clinics.

Notwithstanding, of all medical specialities, dilemmas in reproductive health are recognised to more likely be encountered as the fetus is dependent on others for life. It presumably thereby merits protection. So, this is where practitioners face the greatest conscience test of all: the conflict of interests in dealing with two human lives, either without the ability to self - determine their own wishes and fully or independently exercise their autonomy without medical assistance.

The “Expressing Your Personal Beliefs as a Doctor’ (BMA 2019a) clearly spells out the British Medical Association advice to medics on employment. In the “manifestation of religious and cultural beliefs for both doctors *and students,*” therein, lies the rub – that no matter how experienced or how qualified practitioners are, students' rights remain of parallel importance, but the BMA guidance is criticised by Adenitire (2016) as contravening ECHR human rights law because the lack of emphasis on mandatory enforcement to provide for CO which make it imperative for NHS institutions to do so.

2.7.9 The Rights of Students & Training

Respect for persons, autonomy and freedom of conscience extends rightly to students and their CO features in the BMA guideline also, not only in partaking in abortion procedures but in witnessing them. In abortion, the need for improved training is recognised by the RCOG (2011) nevertheless. A key commentary if provided in the work of Strickland (2012), which features highly in literature searches. He calls for better guidance in training to professionals wishing to reassert their rights and enhance their understanding of conscientious objection. Dealing with taboos is one of the challenges of this research. Thereby the controversy touches on how knowledge, attitudes and practice are reflected, not least for new recruits to the branch of philosophy, learners

and those gaining experience during their professional skills development within training institutions.

2.7.10 A Feminist Bearing on the Topic

Traditionally, feminism attributes the causes of gender inequality to biological differences, including hormonal, amplifying evolutionary strength, innate aggression, and reproductive capacities (Daly and Chesney-Lind 1988). Contemporary feminism is often said to be a revolt against the domesticated, female role personified typically by 1950's media images of middle-class suburbia with the wife, as a predominantly white homemaker and as mother, mainly responsible for childcare. The tsunami waves of feminism added alternative perspectives, evolving as schools of feminist theory. Feminism as a philosophy, however, has proved far from homogeneous and its evolution, far from well-demarcated.

A Marxist feminist view, for instance, argues that the Capitalist causes of gender inequality are derived from hierarchical, master-slave relations of control with the rise of private property and its inheritance - mainly by men (Daly and Chesney-Lind 1988; Armstrong 2020). Marx argued that working-class resistance as a "sex class" (or reserve army of labour), theorises a husband's exploitation of his wife's labour. Despite a move from kitchen to factory, a radical view may argue that a subservience remains, to some degree when employers secure an upper hand. This could be the case in midwifery, a female dominant but predominantly male-led profession).

The 'first wave' in the early Twentieth century (1900-1959) focused on women's suffrage, property rights and political candidacy. Alongside the political emancipation, sexual liberation, workplace rights and financial independence of women, came a societal changing attitude towards reproduction: as a notion of a pregnant woman's property rights to her own body, to dispose of as she wishes (Markowitz 1990). A first wave approach has much to offer in terms of pioneering representation and ground-breaking, legally orientated policymaking.

The 'second wave' during the 1960's until the 1980's, looked at reducing de facto inequalities in sex, family and employment. As a woman became less reliant on her husband as the source of her income, now with agency in the workplace, attention turned to control of her reproduction. This movement came to fruition in more widespread use of birth control and specifically the contraceptive pill.

It is against this background, that the 1967 Abortion Act is set – which together handed back the right and opportunity to determine one's own fertility and maternal destiny. Realisation of reproductive and sexual choices relates most closely to when, how and whether or not to at all, bear and rear children. The question of bodily autonomy is pivotal to the aspirations of feminists but debate still rages around abortion to what extent these rights and liberties have in fact materialised.

In its embrace of diversity and individualism, the 'third wave' (1990's to 2000's) recognised the limitations of earlier models. These had largely overlooked the marginalisation of certain groups on the basis not only of gender, but sexual orientation and moreover, race, ethnicity, class, age, and disability. If certain sections of the community already are discriminated against, then one could presume their freedom of conscience and expression may similarly be even more under-recognised and/or understood. Application of the principles of intersectionality associated with third wave feminism therefore could help more suitably address the needs of the dispossessed and disenfranchised. Considering intersectionality may hone a more sensitive appreciation of equity issues in the research, with an awareness of the importance of a range of representative views. Price (2011: 55) best summarises this multi-faceted nature of sexual identity,

"Researchers must address the interlocking effects of identities, oppressions, and privileges to fully understand the range and complexity of women's experiences. Women (and men) not only experience the effects of gender in their lives, but they are also affected by their race, ethnicity, class, sexual orientation, and (dis)ability, among other aspects of their identities."

The ideology of the 'fourth wave' (2008 to the present day) focuses more on combating sexual harassment, assault, and misogyny. Characterised by empowerment, liberation from social stratification began to be effectually voiced on social media. Fourth-wave feminists advocate greater political representation and proactivity, giving rise to the term "hashtag feminism", which refers to the use of online platforms and their hashtag feature to counter or condemn discrimination, violence, and sexual assault against women (Harp et al. 2018).

One of the ironies of Fourth wave "lipstick" feminism was that it was led by celebrities, whose liberated lifestyles were remote in their resemblance from the majority of the community, yet who still managed to forefront populist issues. They gave publicity to social inequalities, which remain despite the Feminist movement. Another of the greatest paradoxes of the feminist movement is that despite measures designed to

render society wholly more equitable; to address the coercion, violence and oppression, backstreet abortion remains in parts of the globe, galvanising inequality. Whilst the Anglosphere framework laid out in the 1967 Abortion Act did admittedly all but eradicate illegal UK abortion provision, leading the way in the global North, there remain areas worldwide where abortion services remain unregulated, disparate, unavailable, or inaccessible. Together these factors demonstrate far-reaching and reverberating socio-economic, political inequities and power imbalances.

Liberal feminism, on the other hand, maintains that the process of gender roles are formed by socialisation, cognitive development, and social learning. Removal of the obstacles to women's access (in education, paid employment, and political activity) is the main strategy for empowerment enabling participation in the public sphere. Significantly, this is through established institutions. The emphasis is on legal change, and there have been notable successes to this infrastructure approach (from within the system rather than without) – universal suffrage, maternity rights, the Equal Pay Act and Sex Discrimination Act, for example. If one assumes control of one's own fertility as the guiding principle, then the Abortion Act could be seen as the most ardently feminist of these measures. A system of regulated accommodation of freedom of conscience need not necessarily undermine any progress made, however, and may in fact represent an extension of feminist rights.

We have already asked whether conscientious objection is reasonable for service-users? (see section 2.6, pg.52). A feminist from an abortion defense perspective would say 'No! The greatest burden of the unwanted pregnancy impacts most on the woman'. Abortion providers, presumably uphold this in their practice according to the belief that the interests of the woman over-ride those of the fetus. Based on the premise of equality, liberty, and freedom, one popular defence of abortion is grounded on a woman's right to bodily autonomy, avoiding the issue of personhood entirely, argues Markowitz (1990). In what became widely recognised as the ultimate philosophical scenario, Judith Jarvis Thomson ingeniously points out that if a fetus indeed has a right to life, it need not also have a right to use a woman's body to stay alive.

Ironically, the patriarchal values of Victorian society (with its good housekeeping virtues, law and order, religious doctrine, and morality) may have come full circle in post-modernist feminist thinking, which reasserts the woman's right to freely bear and rear children (or indeed to abstain from doing so). Now that medico-legal and technological advances have ensured control over one's fertility, it begs the question – do women necessarily want it? Who did the sexual revolution effectually benefit? And how best can

the new approach to unhindered human rights be facilitated to ensure safety, health, and well-being of the whole family in addition and in harmony with the rights of care providers?

2.7.11 Doing Science as a Feminist

A number of feminist principles are enshrined in the research, making the analysis altogether a more reflective and inclusive examination of a highly gendered topic. An explanation of some of the terminology is aimed at overcoming barriers not only in the conduct of the study, but in the communication of it.

Gender Blind refers to little or no recognition of local gender differences, norms, and relations in program/policy design, implementation, and evaluation.

Gender Aware refers to explicit recognition of local gender differences, norms, and relations and their importance to health outcomes in program/policy design, implementation, and evaluation. This recognition derives from analysis or assessment of gender differences, norms, and relations in order to address gender equity in health outcomes.

Gender Exploitative refers to approaches to program/policy design, implementation, and evaluation that take advantage of existing gender inequalities, behaviours, and stereotypes in pursuit of health and demographic outcomes. The approach reinforces unequal power in the relations between women and men, and potentially deepens existing inequalities.

Gender Mainstreaming assessing the implications for women and men of any planned action, including legislation, policies, or programmes, in all areas and at all levels; a strategy for making women’s as well as men’s concerns/experiences an integral dimension of the design, implementation, monitoring and evaluation of proactivity in all political, economic, and societal spheres so that women and men benefit equally.

Gender Accommodating refers to approaches to project design, implementation, and evaluation that adjust to or compensate for gender differences, norms, and inequities. These approaches respond to the different roles and identities of women and men. They do not deliberately challenge unequal relations of power or address underlying structures that perpetuate gender inequalities.

Gender Transformative refers to approaches that explicitly engage women and men to examine, question, and change institutions and norms that reinforce gender inequalities, and as a result achieve both health and gender equality objectives.

Rather than aiming to achieve "feminist science", Longino (1987: 53) remarked research endeavours should "do science as a feminist". The important distinction here is in the role of the researcher, cognitively, contingently, and logically in the interpretation of findings, shaping research choices. Reflexivity pit stops have articulated from the outset a feminist ethos to avoid the kind of agenda which "eclipses" lived experience and creates gaps between participants' accounts. A Positivist, masculine picture of abortion distorts the legitimacy of freedom of conscience, this thesis maintains.

Generating strategies for change within institutions, described by as "gender-structured systems of inequality" (Hesse-Biber 2007: 570) is the first priority of explicitly feminist goals. The second is a directive to ground feminist research in women's experience and everyday lives. She goes on to explain,

"At the very least the research process should not oppress or exploit research subjects; ideally it should empower them, particularly when they find themselves oppressed....they should counteract hierarchical structures that make social science a ruling practice and implement Egalitarian, participatory forms of knowledge production." (Hesse-Biber 2007: 570-571)

Insofar as one midwife may adhere to these feminist views on abortion, and morally reason conscientious objection entirely the opposite to an abortion critic, the ethical dilemmas raised may be substantially different. It is understanding this decision-making process that is key – does feminist ideology play a part?

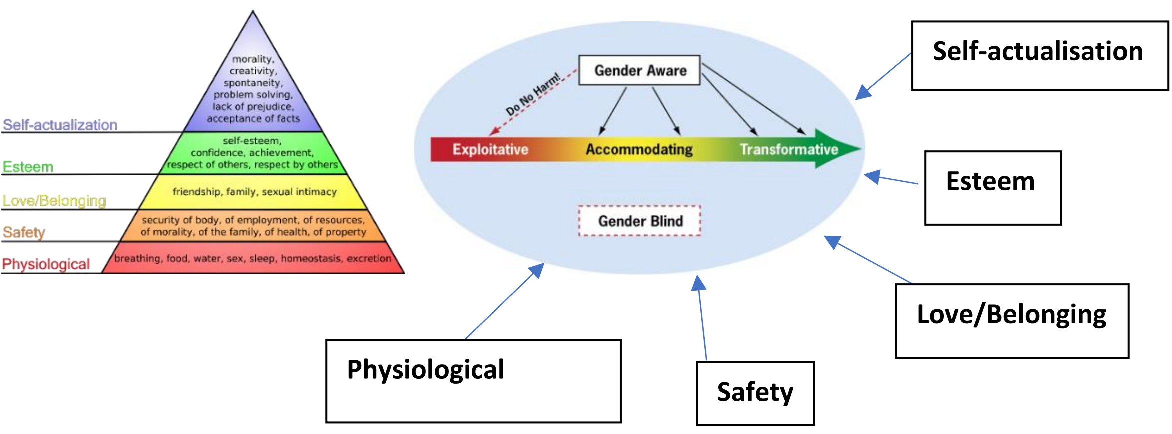
Clement (2019) looks at ethics from a feminist perspective. Her critique of traditional approaches to ethics reveals biases against both women and that which is regarded as feminine. Among the critiques developed are that women have been denied rights granted to men, that femininity has been denigrated relative to masculinity, and that oppression has affected women's ideals and mind-sets.

"By rethinking the gendered dichotomies that have traditionally structured ethics – such as reason and emotion, self and other, and the public and private spheres – and by identifying and exploring moral experiences and concepts – such as care, trust, and epistemic injustice – that tend to be overlooked in male-centered approaches to ethics." (Clement 2019).

Above all, this research encapsulates Gorelick's (1991: 459) adage, "Research undertaken by women, on women, for women". That's not to say that men are excluded, simply a patriarchal culture is. Indeed, a male midwives' insight into conscientious objection makes many conclusions, drawn from within rather than without an alternative perspective, all the more robust. Built into this emancipatory and empowering nature of enquiry is a critical consciousness of feminist location, indeed, but this gives inclusively voice to all participants' dilemmas in ethical decision-making, regardless of sexual identity (or other specifications). "Gender equity and health objectives are mutually reinforcing," states Caro (2009: 7), particularly in reproductive health. To this effect, this study will take into account of gender issues from both male and female perspectives, bearing in mind that *all* people have something to gain a more balanced advancement of human rights. To this end, Caro (2009: 9) describes a tool for identifying and assessing the extent to which gender has been appropriately and effectively integrated into programs: 'The Gender Continuum'. It is aimed at helping program managers more fully understand how gender differences and unequal power relations are treated in the context of health program design and implementation, and with what results, in this case recommendations for freedom of conscience policy. The concepts, explained above, can be adapted to a conscientious objection context in a way that will ensure both male and female midwives as well as service-users benefit from equality (between team members and between cases). Suffice to say, if accommodation of rights is empowering midwives, then an intersectional, gender-aware approach to achieving this is desirable if, as hoped, any initiative is to be truly self-sustaining, and gender mainstreamed.

Figure 8: The CO Gender Continuum

Ref: Adapted from Caro (2009: 9); Maslow's Hierarchy of Needs



The similarity to Wicclairian terminology is interesting since the continuum implies working from 'exploitative' stages in relations through 'accommodation' to a 'transformative' state – a self-actualisation-type realisation, comparable to Maslow's hierarchy of needs (1943, 1954). This is a motivational theory of psychology, comprising a five-tier model of human needs, often depicted as hierarchical levels within a pyramid. Needs lower down in the hierarchy must be satisfied before individuals can attend to needs higher up. The following illustrative model, therefore, represents a model combining both approaches – Caso (2009) and Maslow (1943, 1954). The purpose of its inclusion is to demonstrate the evolving nature of CO, within a feminist framework. The aim is to show how gender-awareness, itself evolving, can link to moral decision-making in it's realisation or transformation.

2.7.12 Arguments Against Conscientious Objection

Savulescu (2001: 295) adopts a converse view of conscientious objection. His first argument is that objection introduces inequity and inefficiency. Those certain cases where abortion is not allowed brings inconsistency and uncertainty, constraints of liberty and discrimination. The most striking feature of Savulescu's research cites estimates that 80% of clinical geneticists and obstetricians specialising in ultrasonography believed that abortion should be available for a thirteen-week pregnancy, but if <u>for career reasons</u> an abortion is requested, then only 40% were willing to facilitate it. Again, we are drawn to a focus on case by case.

An innately private matter of principles and morals, whilst attempting to act nobly and virtuously, for one person may not represent the same attitude for another. What then, asks Giubilini in his later study with Savulescu (2018), are we to do to defend the rights of conscientious objectors in one situation, but not another which could yield a different conclusion depending on which practitioner is exercising his/her freedom of conscience and the determinants of the case?

There are also issues of adequacy of care and the adequacy of justification. As Savulescu (2006: 294) asks,

"If self-interest and self-preservation are not generally deemed sufficient grounds for CO, how can religious or others' values be?"

Conscientious objection, nevertheless, "a guise" for refusal to treat, is harmful because it creates barriers suggests Fiala et al. (2017). For this reason, Fiala denouncing "faith–based medicine", takes a less tolerant view.

Aurthur et al. (2016: 206) looked at three countries – Sweden, Finland, and Iceland – neither of which generally permit healthcare professionals in the public health care system to refuse to perform a legal medical service for reasons of 'CO'. To examine if "disallowing 'CO' is workable and beneficial", in their comparison they concluded that accommodating CO,

"Facilitates good access to reproductive health services because it reduces barriers and delays. Other benefits include the prioritisation of evidence-based medicine, rational arguments, and democratic laws over faith-based refusals. Most notably, disallowing 'CO' protects women's basic human rights, avoiding both discrimination and harms to health. Finally, holding practitioners accountable for their professional obligations to patients does not result in negative impacts."

Significantly, authors suggest one ultimate pre-condition,

"The key to successfully disallowing CO' is a country's strong prior acceptance of women's civil rights, including their right to health care."

To this end, having already achieved a total ban on CO, the Scandinavian model represents "an abandonment of professional obligation to the patient*",* Fiala et al. state. and Aurthur (2014), even coined a term that has had meteorite effects in the debate: "dishonourable disobedience" which denotes, in their opinion, a dereliction of duty and a misuse of their position of trust. CO, they argue, should be dealt with as any other failure to perform one's professional role, through enforcement and disciplinary measures. Fiala and Arthur, interestingly cite examples of abuse of CO to give a clearer impression than most on what does not constitute CO, like non-dispensary of certain oxytocins by pharmacists or perverting administrative procedures to use lies and deceit in avoidance of abortion workloads. Calling for its abandonment, the solutions to the CO problem are likely to be "unworkable, inappropriate and unenforceable" (Fiala and Arthur 2014: 18).

Giubilini (2014) ranks abortion with physician-assisted suicide because of the lack of status afforded to life. He distinguishes between types of CO that can be granted and those that cannot. The question remains, who is doing the granting? Who allows these two cases to be treated differently "with principled reason"? Justifying objections, with examples of acceptable and unacceptable forms, leads Giubilini to urge practitioners to avoid appealing to conscience whatsoever – quite a different perspective, indeed, to those arguments earlier presented.

Harris et al. (2016: 2) appear to intimate, anarchy results, masking social, economic, and political factors.

"Like civil disobedience, CO is rooted in moral conviction."

and this disobedience is "dishonourable", according to Fiala et al. (2014) because it infringes on fundamental rights whilst placing all the burden including risks to health and life, on the shoulders of women. A systematic review conducted by Fleming et al. (2018) of 1051 articles methodically examined the reasons for CO as cited in the literature. Authors concluded there were no conclusive arguments either for or against (see Appendix 9).

To limit the scope of CO, shape policy, effectively plan for management of freedom of conscience, more information is needed about how CO is practised, creating an enabling environment Harris et al. suggest. Enabled then, is surely one in which moral reasoning is understood, freedoms can be expressed, self-determination realised, and autonomous decisions fulfilled in the full spirit of ethical decision-making.

2.7.13 Literature Review Conclusion

So far, midwives moral reasoning and decision making have been explored from a variety of theoretical perspectives. The literature review began with the umbrella view of 6 themes elicited from findings, the underpinnings of the research. The literature review started with a theological view (including an inwards looking examination of what is conscience?) then onto 'navigating with a moral compass', a societal view which included norms, behaviours, and opinions about what being reasonable comprises. In the moral imagination the '-isms' (relativism, objectivism, constructivism, subjectivism, perspectivism) all provided alternative angles to see CO. Different deontological or teleological/consequentialist theories contributed to the 'ethics' debate. We saw how applying rules or virtues might help support midwives, supporting women. This flipped to a converse view - the inner voice mechanisms of moral reasoning which determine how understanding of the philosophical components of 'conscience' impact on interpretation of rights and beliefs are acted out. Throughout, the literature review incorporated a spotlight on 'CO', itself a springboard for further debate, in realisation of all four ethical principles: beneficence, non-maleficence, autonomy and justice in healthcare practice.

Ethical theory has been used to examine the thought processes with which midwives internalise a plethora of self-questioning both religiously motivated, in the theme 'Practising Midwife, Practising Religion' and conscience based in 'Navigating with a

Moral Compass ‘. This materialises in a response to CO crises, in which midwives may feel ‘Torn Between Wearing Two Hats’, a theme which relates more to professional practice in contrast to personal personae, but which nevertheless compounds the turmoil, the conflict, the lived experience of ethical dilemmas. The fact remains that despite the professional guidance aimed at reinforcing uniformity and consistency, everyday practice in the dynamic field of sexual and reproductive health, remains fraught with complexities. Medico-legal issues, addressed in the theme entitled ‘Two signatures and the escape clause’ reiterated the ubiquitous nature of dilemmas as much as the statutory requirements for two medical practitioners to certify ‘in good faith’ by signing form HSA1 (certificate A in Scotland) that at least one of the four criteria of the Abortion Act applies. ‘The right midwife delivering the right care’ involves examination of those solutions put forward in the literature for accommodation of any CO that may arise in participating with any of the procedures instigated by this.

Having explored freedom of conscience theory, thus, what constitutes the methodology to identify lived experience of dilemmas amongst midwives will now be highlighted. For the first time in this ground-breaking study, the deep-seated philosophical and psychological raison d'etre for best appreciating midwives’ rationale today about CO will be illuminated. This centres on giving an opportunity for a platform for participants to voice their own unique perspectives which has served to amplify the inner voice of conscience, ever elusive, sublime, and subjective. Although none of the participants were outwardly objectors, most expressed their position was conditional – even the abortion provider within the group remarked they would object under certain circumstances. Others voiced that they chose a Maternity career path that does not proactively involve them in abortive cases. This was the crux of the lived experience: how a given person makes sense of a given situation at a given time. The moral reasoning around these ethical questions was common to all, part of the IPA homogeneity. Insight into how beliefs transform into manifest action (or motivate individuals to decline action, as the case may be) and how these impact on care, will lead to discussion on the effectiveness of policy based on the legal provisos made in The Abortion Act. This will be achieved by a distinctly phenomenological approach one which features a novelty or phenomenon. Hermeneutics will best afford an opportunity for participants‘ own sense and meaning making of CO as that enigma, which will be interpreted using an IPA lens.

Chapter 3 – Methodology

3.1 Introduction

The aim of this chapter is to address the methodological principles of the PhD study. In short, this chapter will discuss how to set about achieving the aims and objectives. It will discuss what the philosophy is behind methods chosen to study a topic so far only reviewed in the literature. It will acknowledge the underlying ontological position and epistemological stance in relation to CO. The theoretical underpinnings of IPA will be outlined before addressing relevance to freedom of conscience which will clarify the rationale for IPA as the methodology of choice for this paper. The tenets of IPA – phenomenology, Hermeneutics, idiography – and how these philosophical underpinnings align with an exploratory study in the field of CO will be examined.

With its background in developmental psychology, early IPA works were in line with the main stances of a qualitative methodology: they followed a knowledge-producing and theory-generating logic (rather than testing existing theories and ex ante formulated hypotheses). However, IPA was a new departure in many ways: examining the stance from the perspective of the individuals and the perception of reality; avoiding artificial settings; doing research in everyday contexts; then reflecting the process of production and construction of the data (Demuth and May 2015). Largely, the iterative nature of IPA research covers novel, under-researched subjects yet explicates structure in these subjective, detailed accounts (Smith and Dunworth 2003). It is precisely this exploration which confirms IPA's suitability, particularly in developing areas of health studies and human sciences. According to Steinmetz (2005), the diverse, unorthodox, and non-homogenous nature of the engagement brought by a qualitative paradigm best bridges the gap between the researcher as knower and its ontology, the knowable (or that which they seek to know).

"IPA simultaneously adopts a Relativist ontology and a Critical Realist epistemology" argues Willig (2008). Grace and Priest (2022: 207) further justify why these approaches are appropriate,

"Relativist because it recognises the varied and idiographic nature of existence; realist because it accepts that there is an external reality."

In section 2.3.6 we have already looked at the concept of relativism insofar as judgments are true or false only relative to some particular standpoint (for instance, that of a culture or a historical period). The example of abortion was cited to illustrate "if a person believes that abortion is morally wrong, then it *is* wrong – *for them*." In short, what this means is that no standpoint is uniquely privileged over all others. Now this principle will be applied first to the thesis' ontology, then in relation to the subject, before the consideration of its epistemology.

3.2 Ontology

Ontology is the subject of beings or their being, so to this end the thesis will assume the reality of being can only be understood via the human mind (Snape and Spencer 2003; Jeong and Othman 2016) and each perception is relative. Ontology is concerned with what actually exists in the world about which humans can acquire knowledge. As a branch of philosophy, it is the science of 'what is', the study of object. Ontology helps researchers recognise how certain they can be about the nature and existence of objects they are researching. For instance, what 'truth claims' can a researcher make about reality?

Philosophers sometimes ask the question, 'who decides the legitimacy of what is 'real'? As researchers dealing with different and conflicting ideas of reality, the ontological perspective of this thesis will answer the practitioner themselves, relative to the perspective of another, the service-user. The arguments presented are underpinned by the core principle of sovereign rights to realise autonomy but to exact self-determination is relative.

3.3 Epistemology

By comparison, in its simplest terms, epistemology is 'how we know what we know', a theory of knowledge. Epistemology deals with how knowledge is understood and gathered as well as from which sources. In research, epistemology is concerned with all aspects of the validity, scope, and methods of acquiring knowledge, such as a) what constitutes a knowledge claim; b) how can knowledge be acquired or produced; and c) how the extent of its transferability can be assessed. Epistemology is important because it influences how researchers frame their research in their attempts to discover knowledge. Therefore, it is deemed opportune to outline one's philosophical standpoint from the outset (Engward and Goldspink 2020; Emiliussen et al. 2021).

Bhaskar (2008) links IPA epistemology and critical realism, when he posited that structures may exist that cannot be realised. Therefore, in cause/effect relationships, particularly in the study of humans – in the social sciences – there is insufficient evidence to support a simple interpretation of social events, Bhaskar suggests. How phenomenon become phenomenological is too "multi-directional and fluid" to be understood so simply, Bhaskar argues (Grace and Priest 2022: 207). Extrapolating the individual voice from the complexity of multiple hermeneutics is something that Love et al. (2020: 1) describe as "navigating the bumpy road" of "iterative loops," "idiographic journeys", and "phenomenological bridges", critically. Grace and Priest categorically support Willig and Bhaskar,

"The epistemology that underpins IPA is Critical Realism. Strictly speaking, Critical Realism is a philosophy of ontology but also informs how a theoretical view of reality can be actualised….Critical Realism's position is that the material world does exist, but the processes by which we understand it –perception and language – are more like mapping tools than direct representations and so are subject to variation. Therefore, the meanings ascribed to material objects of experience are an interpretation of that experience." Grace and Priest (2022: 207)

Critical realists believe in the distinction between the 'real' world and the 'observable' one, both inter-dependent and socially constructed, so it is a useful framework especially in social science (Fletcher 2016). Critical realists recognise that the perspectives of key players within the environment may affect outcomes in what is conceived as knowledge. Whatever view of the world and whatever perspective the phenomenologist has on what comprises knowledge can potentially strongly influence interpretation of data (Van Manen 2007). The idea that the researcher is part of the research, never fully separate, impartial, or removed, will inform the theoretical perspective of this thesis. Bias is acknowledged as inevitable. According to Horrigan-Kelly et al. (2016: 2), this is typically a very Heideggerian rejection of the notion of the human being/subject as a spectator of objects, espousing that both subject and object are inseparable. For Heidegger, "being" was thus the descriptions or accounts that "*Dasein*" (being there or man's existence) provided of their everydayness or ordinary existence (Heidegger, 1927/1962). Heidegger thus asked from a philosophical stance "what does it mean to be?" (Heidegger, 1927/1962)."

Phenomenology, which studies our experience of a phenomenon, is distinct but related to other key disciplines in philosophy, such as ontology, epistemology, logic, and ethics,

which is why it is suited to a study which recognises each of these. The idiographic focus of IPA means that instead of producing generalisation through its findings, it aims to offer insights into how a given person, makes sense of a given situation, in a given context. Grace and Priest (2008: 211) therefore draw conclusions that it is,

“Recognised that a reality exists, the idiographic focus of IPA ensures that the subjective quality of perception is never omitted and that objects are only qualified as they appear to us and not as they are.”

This is very much a feature of an IPA approach to moral reasoning and ethical decision-making – the essence of thinking and the controversies around CO. To this end, this study adheres to a Critical Realist episteme and an IPA methodological position which examines ‘what is’, ‘how it is’ and ‘what is the experience’ of ethical dilemmas in moral reasoning associated with conscientious objection to abortion.

3.4 Rationale for a Qualitative Paradigm

Cresswell and Cresswell (2013) support the advantages of conducting qualitative research when a problem needs to be explored. It is needed in circumstances in which variables cannot be easily measured or in which “silenced voices” (2013: 47) need to be heard. Objectors are often bullied and marginalised, under pressure to conform. How they come to this conscientious objection is largely excluded in the literature. The conscientious objectors’ perspective may be ambiguous, puzzling, often oppressed in practice and mostly under-acknowledged. The main gap in the knowledge particularly focuses on reasoning, so IPA is used to co-create the meaning regarding/behind those decisions. Not least because ethical decision-making in CO is an essentially internalised process. Although abortion is hotly contested, seized upon, and politicised in the public domain (Boyle and Armstrong 2009), there is a lack of awareness and understanding about CO itself, even amongst healthcare professionals (Dobrowolska et al. 2020). Much of the popular campaigning centres on the pregnant service-users’ rights to bodily autonomy (“My body, my choice*”,* it is proclaimed). Providers are viewed to be in service of that need. Converse views of the unborn ‘child’s’ right to life make the practitioner’s rights even more obscure, almost as if an afterthought, caught somewhere in a moral acceptability ‘no man’s land’ (Clarke 2017: 97). One side is against abortion because they see it as killing, the other side, because it is not viewed as killing. It is viewed as part of healthcare. Between the debated camps, true impartiality is impossible (Clarke 2019: 679).

3.5 Alternative Methodologies

There were mainly four alternatives considered in depth as a possible methodology of choice for best exploring the phenomenon of moral reasoning and ethical decision-making in relation to conscientious objection to abortion. These were: ethnography, grounded theory, hermeneutic phenomenology, and thematic analysis. Each of these will now be considered in turn.

3.5.1 Ethnography

In ethnography, data are collected through observations and interviews, which are then used to draw conclusions about how societies and individuals function. The culture-sharing and patterned behavioural characteristics of ethnography are built on social sciences, in particular anthropology. In this methodology, the researcher is embedded in the group or community they are studying, so what is being observed is recorded. Ethnography learns from rather than studies a cultural group whereas IPA applies more idiographic, initially case-level, using iterative techniques. Ethnography is largely relational whereas IPA affords an opportunity for reflecting and participants' vocalising their own insight. Researchers observe and analyse changes in behaviour over time, but time constraints determined ethnography a less feasible option. Heideggerian principles 'In Being and Time' more encapsulate a snapshot, contextualised to the contemporary situation and current developments within the field. Although the main advantage of ethnography is that it gives the researcher direct access to the culture and practices of a group (useful for learning first-hand about the authentic behaviour and interactions of people within a particular context), there are ethical considerations in studying conscientious objection in this manner. In the most poignant sense adopting ethnography would incur being alongside the research phenomenon *as it was happening* (I doubted if ethical permissions would have been granted). Ethnography explores the lives of others in their natural environment (whereas IPA afford the opportunity to give voice to participants' reflecting on cases) and for this reason IPA was preferred, since ethnographically gleaned data may be too general to be useful, potentially subject to observer bias (remembering that reflexive bracketing is less pronounced than in IPA).

3.5.2 Grounded Theory

Construction of a hypothesis and theories through collection/analysis of data are integral parts of grounded theory, involving *inductive* reasoning. This infers a general rule,

conclusions, and broad generalisations, which are derived from body of observations. By comparison, deductive reasoning starts with a general rule or principle, applied to different situations or a specific case. For an exploratory study of this kind, therefore, where I wanted to design research questions relevant to practitioners within the field, and applicable to practice, IPA was a more appropriate fit. Grounded theory attempts to unravel the meanings of people's interactions, social actions, and experiences: these explanations are grounded in the participants' own interpretations or explanations. Although it is maintained, researchers allow the data collected to guide their analysis/theory creation without any preconceived hypothesis about outcomes, and are not concerned with validation or description, the supporting evidence reviewed suggested IPA would better lead to refreshing, novel discoveries in such an under-researched area.

3.5.3 Hermeneutic Phenomenology

Advocates of hermeneutic phenomenology expound a belief in the importance and primacy of subjective consciousness. Hermeneutic phenomenology asserts that individual people are as unique as their life stories. Not unlike other phenomenological methodologies, what is most pivotal are the meanings of an individual's being in his/her lifeworld. How these interpretations influence the choices that the individual makes is key. In hermeneutic phenomenology, findings are orientated to description and interpretation, recognising the pedagogical value of this experience. Like IPA, essential idiography in the lived experience is a philosophical underpinning but the model provided by Smith, Flowers and Larkin (2022) encapsulates a well tried and tested method to achieve this. Hermeneutic assumes we gain knowledge by a kind of reflection (Cohen et al. 2000), but IPA better helps us learn in-depth, hermeneutically, and heuristically from the experiences of others, conceptualised rather than simply experienced. Hermeneutic phenomenology interprets narratives to their own contexts to illuminate their understanding, similarly robust and nuanced, yes indeed, but in IPA there is a greater component of sense and meaning making given to the reflection. The interpretative qualities of IPA focus more on the 'Double Hermeneutic' – the participant's sense and meaning making themselves of their own situation in co-production of knowledge. IPA looks iteratively more at clustered ideas, commonalities, and areas of divergence/ convergence between as well as within case level lived experiences. In this study, there were multi-perspectives, a plethora of views and many participants, with a greater interpretative role for the researcher. Although Suddick et al.'s (2020: 1) paper,

“Makes a case that hermeneutic phenomenological work is detailed, lengthy, rigorous and systematic in its own philosophical and theoretical frame,”

one criticism of hermeneutic phenomenology is that its analysis of stories is towards phenomenological themes rather than emergent themes about/from the participant(s) making data subjective and data validity, difficult.

3.5.4 Thematic Analysis

Thematic analysis is a method of analysis for seeking to understand experiences, thoughts, or behaviours across a data set. The six-step framework provided by Braun and Clarke (2013) provides a powerful, accessible yet flexible method
for analysing qualitative data that can be used within a variety of paradigmatic or epistemological orientations. Themes are actively constructed patterns (or meanings) derived from a data set that answer a series of research questions (as opposed to mere summaries or categorisations of codes). Themes can be generated inductively or deductively. Widely used, yet often misunderstood, there is often confusion regarding thematic analysis as a method and its philosophical underpinnings. Imprecision in how it has been described have complicated its use and acceptance among researchers. Such a tool was deemed too prescriptive for this study. Compared to the rigorous application of IPA’s PETs and GETs, it could be critiqued as too descriptive. The coding in thematic analysis, like in grounded theory, breaks data into chunks. This may result in a loss of context and narrative flow. IPA is always about the subjective lived experience, whereas thematic analysis can be about that, or about any number of other things. In patterning meaning across participant data, thematic analysis is said often to not capture nuances of difference and divergence. IPA focuses more on the unique characteristics of the individual with idiographic focus. If the goal is to understand individual experience, IPA is the better choice. IPA offers insight into how a given person makes sense of a given situation in a given context. By comparison, thematic analysis is not a methodology. It is a method/design approach. IPA has data analysis steps aligned more with Hermeneutics.

For these reasons, the four alternatives were discounted in favour of IPA.

3.6 The Contribution of IPA

Examining the phenomenon using IPA draws on a plethora of disciplines – medicine, law, nursing/midwifery, psychology, philosophy, and theology. The focus of IPA: in-depth

exploration of personal experience – affords an opportunity to capture individual perceptions of phenomenon (Smith and Osborn 2008) as these make sense and meaning to the participants themselves. Specifically developed by Smith (1996) as a technique for answering research questions in health psychology, IPA, suggests Smith, crosses the research "divide between cognition and discourse" (Smith 1996: 261).

Many researchers thus recommend IPA for healthcare research (Biggerstaff and Thompson 2008; Smith, Flowers, and Larkin 2009) owing to its "essential simplicity, paradoxical complexity and methodological rigor as a research tool" (Biggerstaff and Thompson 2008: 2). Whilst IPA, as a family of research methodologies, is without orthodoxy, yet IPA brings rigour, DeJonckheere and Vaughn (2019) promote. Just as IPA takes researchers "to the heart of the patient's lived experience" (Biggerstaff and Thompson 2008: 3), so too there are endless possibilities for capturing both personal and professional conscientious objection multi-perspectives (McInally and Brunton 2021), especially as an under-researched area. IPA helps give an idea how people arrived at those decisions. IPA offers an adaptable and accessible approach to phenomenological research intended to give a complete and in-depth account that privileges the individual (Alase 2017).

In conscientious objection, those individuals are making decisions and affecting abortion access. IPA enables research practitioners to reach, hear and understand the experiences of participants, in this case, the decision-makers' decision-making process. "For the researcher seeking to explicate intersubjective knowledge" (Charalambous et al. 2008: 640), the IPA researcher is positioned within interpretation, so findings from IPA studies can both influence and be influenced. A hermeneutic approach takes into consideration the values, beliefs, and culture ('historicity' as Ricoeur calls it), all important parts of midwifery decisions and its moral reasoning. IPA contributes to theory and provides a platform for practitioners' sense and meaning making of the phenomenon (Pringle et al. 2011). In the same manner as CO, topics that are best suited to IPA are "complex, ambiguous, emotionally laden or…. difficult to articulate" (Smith and Osborn 2015: 42). It is a *hot* rather than *cold* matter, a trajectory of feelings – one that is affective, rather than cognitive alone. Smith (2021) calls these malevolent forces "getting out of the black box" of psychological constraints, because these cryptic forces which leave practitioners so troubled can then be tackled more transparently.

It is in this regard that the current PhD study covers fresh ground, representing a new departure in the field of conscientious objection. Although Hermeneutics have been

increasingly used since the 1970's in nursing (Charalambous et al. 2008), bringing a storehouse of pre-understandings to everyday life's events (Finch 2004: 253), the challenge is using IPA with professionals in the midwifery field, on the matter of conscientious objection. What the concept means to different practitioners in often unique and varying circumstances are central to the context of the decision. In attempts to redress an inharmonious imbalance, between practitioners' rights and service users', the current law is argued to make limited institutional provision for exercise of workplace rights, by focusing on the individual's responsibility to declare their objection and refer accordingly to a non-objecting colleague. IPA elicits responses to vocalise midwives' interpretation of how functional this premise is.

Rather than singular theory, IPA as an approach represents numerous thinkers (Moran 2000). In thus producing a phenomenological, but objective account of a subjective experience – IPA has been likened metaphorically to a "guide rather than a cookbook" (Smith 2021). IPA does not represent a prescriptive recipe to concoct repeatable interpretations and replicate experiments. In a practical application of the phenomenological approach, "One learns about phenomenology by doing it and making it one's own" (Merleau-Ponty 1945: xxviii). It is perhaps this characteristic more than any other that makes IPA so popular amongst contemporary researchers in such wide and varied applications. One of the newest developments has been its focus on managerial teams and this is valid for policymaking. Exploring the variety of the human experience of the same phenomenon through the lenses of different individuals contributes to the growing use of phenomenological research in management and organisational research (Gill 2014). Examining CO through IPA is one way of reaffirming its advantages, furthering how the future of work is being shaped by global and fundamental changes in employment (Bonache and Festing 2020; Harney and Collings 2021).

Probably there are as many interpretations of decision-making as objection circumstances, as many interpretations of experience as philosophers, so an adaptive methodology capable of reflecting these nuances, suspended in being and time, is well-suited to its multi-facets. A holistic phenomenology conclude Smith, Flowers, and Larkin (2009) affords greater opportunity for analysis which is case-level (participant focused) and cross-case (between participants). This is ideal for a more versatile reflection of freedom of conscience, in a re-look at the proviso for decision-making in relation to freedom of conscience made in the 1967 Act.

3.7 Insider/Outsider Perspectives

In health psychology how health is perceived as a constructed aspect of illness, helps explain our reaction to it, Smith (1996) suggests. Given how illness and healthcare are viewed is an important part of the conception of CO. Relating to ideas about its moral permissibility, so perception of what conscience comprises can be said to be an important part of the study. As a practising clinician, I reflected I was already part way there in this endeavour. From the stance of researcher-practitioner, this “insider” viewpoint (arguably never completely achievable (Conrad 1987; Schleiermacher 1998) affords an understanding of a spectrum of CO views and decision-making relating to that abstention. Making sense of what is being said or written involves close interpretative engagement on the part of the listener or reader (Charlick et al. 2016). IPA tradition allows wider comprehension of the lifeworld, where the researcher is pivotal in making sense of the participant making sense of their own situation. Then they add meaning. Through the two complimentary commitments of IPA ‘giving voice’ and ‘making sense’, researchers seek to attain an ‘insider perspective’ of lived experiences, argues Noon (2018). Professional midwifery knowledge is a pre-requisite for this, it is deemed.

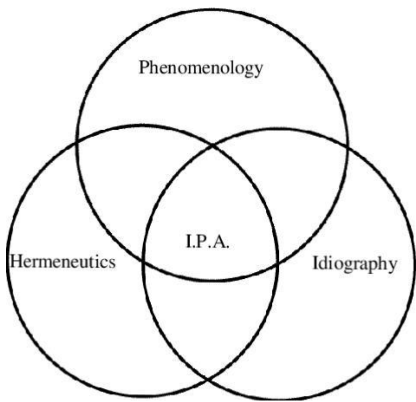
3.8 IPA's Philosophical Foundations

4. Reflexivity Pit-Stop – My Experience of Conscientious Objection

My main experience of CO was as a student nurse. It was raised in my application for the educational programme, and I was asked what I would do to care for a woman undergoing abortion. As a young workaholic, I was fiercely feminist and stated the best answer I could to get me a placement. A more practical example of a 'co crisis' was as I was qualifying, undertaking elective placement in gynaecology theatres. Knowing I was a successful in my midwifery application, I had opted for a location where I thought I could learn most. When broached by the 'scrub' nurses, I again reiterated my willing consent, pleased for my freedom of conscience rights to be recognised and my choice, to be respected. What I remember about every abortion case, for whatever reason, was that the patients cried undergoing general anaesthesia. One of the Anaesthetists was Latin American, Roman Catholic in belief, and routinely did not provide his services for those cases on the ***day afternoon list. This was accommodated, I recall without much ado. Once a lady cardiac arrested when the general anaesthesia was being administered. As the most senior member of the resuscitation team, he attended the emergency as first responder and dispensed his duties, saving the woman's life. I was impressed by his professionalism, especially since everyone knew he was a declared objector. During my learning, I had once declined involvement for an abortion for social reasons, but it was observing his efficient practice than confirmed my resolve not to discriminate or judge other people. My commitment as an abortion-defender, was confirmed conducting maternal mortality audits in low-income settings sealed my motivation for an elimination of unsafe, backstreet abortions. I have passion for Safe Motherhood for all. In the thesis this made me more sensitive to the 'ding dong' Maternity environment and how conscientious objection can cascade – I remembered this scenario in understanding freedom of conscience in emergencies, and its practice related to the law. I remembered it when 'thinking fast and slow' and it materialised in the framework of moral reasoning.

The three substantive areas that underpin the theoretical basis and inform IPA theory (Smith et al. 2022; Squires 2023) will now be examined referring to key CO commentary. A fourth dimension (sometimes treated as an epistemological approach): symbolic interactionism is added because as a relativist and critical realist philosophy, much is contributed to the sense and meaning making on a linguistic level.

Figure 9: Philosophical Underpinnings of IPA



3.8.1 Phenomenology

For Husserl (1859-1938), widely acknowledged as a founding father of (certainly contemporary) phenomenology, “going back to the things themselves” (1900/1907: 252), was the essence of consciousness. Cognition, logic, and the philosophy of the mind were key to Husserlian thinking. Phenomenology involves stepping outside of our everyday “natural attitude”, as he called it, to adopt a degree of “phenomenological attitude”. In short, a view that is rather more reflexive “to gaze on our own psychic life” (Husserl 1927: para 2) is essential. This disengagement, which is often taken for granted, uses ‘intentionality’, a technical term invoked by Husserl to describe the direction or purposefulness of becoming phenomenologically aware, a constitutive act of meaning-making (Smith, Flowers, and Larkin 2009: 13). Intentionality is an idea introduced by Husserl that relates to the necessity for consciousness to exist as consciousness of something other than itself. Husserl himself analyses collective intentionality in terms of three central ideas: intentional act (or psychological mode of a thought). This relates to the particular kind of mental event, whether this be perceiving, believing, evaluating, remembering, or something else. The intentional act can be distinguished from its object, (the topic, thing, or state of affairs that the act is about), and intentional content (the way in which the subject thinks about or presents to herself the intentional object).

In Husserl's terms, only then can an utterly new from nowhere, "God's eye" perspective be achieved (Moran 2000: 12). The aim ultimately is a "close" rather than "far" experience, characteristic of a phenomenological demystification (Smith 2011). Although abstract and complex, Husserl's position, labelled 'transcendental phenomenology' (Husserl, 1927: para. 3) has important connotations here. Basically, with transcendental phenomenology, the researcher seeks to obtain an unbiased description of the raw data, a clear and undistorted way things appear in our consciousness (Yee 2019).

Setting aside all preconceived ideas (epoche), the researcher is enabled to clearly enlighten everyday phenomenon through "unclouded glasses" (Larkin and Thompson 2012: 99). Of course, as in any social science, it is disputable whether this gold standard of non-bias is attainable, and even desirable given the interpretavist facet of IPA (Larkin et al. 2006). Merleau-Ponty (1945: **vii**) later terms this *"entre au monde*" or 'being in the world'.

A key IPA attribute is allowing true meaning to evolve with its own identity, useful for this novel, exploratory study. Notwithstanding the limitations of achieving this are recognised. Gestalt connections between an individual and the world in this case, located in the ever-changing maternity workplace is critical to our understanding of the dynamic context in which midwives practice.

3.8.2 Hermeneutics

In its simplest terms, hermeneutics means interpretation. But "How and what to interpret?", asks Zimmermann (2015). Hermeneutics is understanding and making oneself understood which therefore requires art rather than rule-governed science. Hermeneutics is also the name for the philosophical discipline concerned with universal conditions for understanding. According to Zimmermann, Hermeneutic thinkers are defined as those concerned with understanding in 3 areas: the nature of consciousness, the nature of truth and the importance of language. The term is taken from Greek 'to interpret' or 'make clear' and named after *Hermes*, the Greek deity who translated the deities' message to humans (Pietkiewicz and Smith 2014).

Given the premise "phenomenology begins in silence" (Finlay 2014: 121), Heidegger built on Husserl's ideas. Heidegger rejected Descartes' notion of the human being as a subjective spectator of objects. Heidegger's book 'Being and Time' instead holds that both subject and object are inseparable. In presenting the subject, "being" as inseparable from the objective "world," Heidegger introduced the term "Dasein" (literally

being there), intended to embody a ‘‘living being’’ through their activity of ‘’being there” and “being in the world” (Horrigan-Kelly 2016) The primordial state of affairs is the ordinary condition of inert beings. In themselves, they are soundless, mute. Influenced by Aquinas and Aristotle (Smith and Osborn 2015), Heidegger’s theory of Hermeneutics adopted an existential approach which purports language speaks. Heidegger remarked,

“The unsaid (implicit meanings) live always exceedingly as that which the said is about” (Heidegger cited in Finlay 2014: 19) which means that ‘sachen’ (or what matters) is “Looking for the explicit but listening to the implicit” (Staller 2015: 411).

Philosopher and phenomenologist, Merleau-Ponty also examined the meaning of human experience. His Structuralist position was later to influence Left Modernists Jean-Paul Sartre and Simone de Beauvoir. Merleau-Ponty similarly talked of recognising not only what is said, but what is not. He remarked,

“Beneath the chatter of words, the primordial silence” (Merleau-Ponty 1945: 184).

Both Heidegger and Merleau-Ponty’s focus related to the disentangled human condition- ageing and death, life and relationships, being and becoming, embodiment and identity, project and meaningfulness, belonging and needs, freedom and expression (Finlay 2014). Although in a value-driven world, suspending judgments may be desirable, to secure a presupposition less stance, others suggest this is both impossible and undesirable. Gadamer (1975) claims that language is the universal horizon of hermeneutic experience; he also claims that the hermeneutic experience is itself

---

5. Reflexive Pit-Stop - Post Data Collection, What Have I Learned?

In data collection, the approach was one of developing a partnership between participant and researcher to equilibrise power imbalances, a power that participants did not have because of familiarity with the subject of CO and the study’s objectives. Even so, there were revealed some rewarding results because mostly participants and researcher agreed. In fact, they saw eye-to-eye on a lot of CO matters, drawing on both experiences and interactions between the researcher and the research proved rich and yielding. The feature that the interviewer has a combined practitioner/researcher role proved advantageous in clarity of medical points, understanding terminology, an appreciation of contention and insight into ethical decision-making.

---

universal. Gadamer talks of a 'horizon' as a way of conceptualising understanding. In the limits of what we know, your horizon is as far as you can see or understand. The questioning of prior knowledge, towards which one may venture is thus, a 'fusion of horizons'. In the quest for *erleben (*that eureka! moment) a fusion of horizons is rather more accessible and more likely with moderation (Gadamer 1975).

According to Bernstein (1982), Gadamer's perspective on praxis serves as an exemplar for all disciplines who deal with moral, practical issues. Gadamer's distinction between theoria (theory), techne (technical knowledge and expertise) and praxis (practice) is pertinent to a multidimensional examination of conscientious objection as all three elements are essential in the art and science of midwifery. In 'Truth and Method', Gadamer (1975) calls for sympathetic "Hermeneutical understanding", a sensitive and empathic approach in research and praxis which underscores caring for others (Roy and Oludaja 2009: 255).

Aspects of the lived time, lived body and lived relations, thus resonate in this study. Ethical decision-making and associated dilemmas, for example, as a transient concept may be difficult to capture and call for a well-balanced, reflexive approach. With its interpersonal features, the Existentialism of Sartre is about being in the world with everydayness. This places accent particularly on ethical issues and moral dilemmas (Smith, Flowers, and Larkin 2009; 2022) which is where Sartre's work is relevant to the study of decision-making. Sartre believed human consciousness, or 'no-thingness' (*néant*), is in opposition to being, or thingness (*être*). Consciousness is 'not-matter' and by the same token escapes all determinism. A contemporary of Sartre and Merleau-Ponty, Riccouer wrote also on theology, though he is more widely known for philosophy, so his contribution to the understanding of conscience is pertinent. Likewise, a Hermeneutic phenomenologist, Riccouer discussed the concept of identity and empathy as well as the Hermeneutics of questioning and being critical – so important in striking a balance (Smith et al. 2022). The resulting tensions in study design, between suitable depth and breadth of analysis, suggests Staller (2015), call for the researcher to negotiate the "politics of science, politics of evidence, politics of methods" (Staller 2015: 395).

Unlike discourse techniques, "IPA believes in a chain of connection between embodied experience, talking about that experience and a participant's making sense of, and emotional reaction to, that experience" (Smith 2011: 2). It is a lived experience as

distinguished from the linguistics of constructing a “surface-level” account (Peat et al. 2019).

3.8.3 Idiography

Having an idiographic focus means that instead of producing nomothetic findings, IPA aims to offer insights into how a given person, in a given context, making sense, and meaning of a given situation. Usually, these situations are of personal significance and “concerned with the particular” (Smith, Flowers, and Larkin (2009: 29). Smith and Osborn (2015: 42) state IPA,

“Produces an account of lived experience in *its own terms* … specifically idiographic in its commitment to examining the detailed experience of each case in turn, prior to the move to more general claims.”

“The subjective stresses and emotional roller coaster ride of the experience” (Willis 2015: 6) are very much an individualistic, lived experience. Despite contextualisation, IPA does offer a group level view as well as in-depth examination of the solitary case *in its own* right. Idiographic research does make contrasts and comparisons, between constituent participants. It is, nonetheless, contingent, and faithful to the individual (Alase 2017).

For example, Eatough and Smith (2017: 3) use the analogy of research being a journey of discovery to illustrate that IPA helps us see the ‘whatness’ and distinguish between areas of convergence and divergence, in case and cross level analyses,

“What train journeys have in common, their whatness, (is) the invariant structure which makes a train journey a train journey rather than a boat or car journey.”

Overall, more focused on data within rather than between superordinate subsets, the advantage of using IPA, therefore, is a more in-depth analysis. IPA scrutinises layers of comprehension, just like peeling back an onion.

3.8.4 Empathy in Capturing the Lived Experience

As a reminder, IPA is a philosophy that emphasises the importance of understanding subjective experience and how individuals make sense of their world. As an interpretative methodology, significantly, researchers aim to understand the meanings

that individuals attach to those experiences. Denzin and Lincoln (2018: 502) describe interpretation as,

"An art; it is not formulaic or mechanical. It can be learned, like any other form of storytelling, only through doing".

Uncovering different lived experiences seeks to emancipate rather than control a phenomenology between participant and researcher which Finlay (2005: 271) terms 'reflexive embodied empathy'. This connects first through 'bodily atunement' (doubling and mirroring) in oneself and others; then imaginatively intertwines by 'self-transposing' oneself. These ideas (originating in Merleau-Ponty, 1964/1968: 138) finally, result in a united self-understanding and other-understanding. Certainly, sharing a mutual experience is key to any human interaction, in which empathy is a prerequisite. It is critical to understanding moral reasoning and ethical decision-making which Hermeneutic reflection helps appreciate.

Vendrall Ferran (2015) suggests the tradition of the early phenomenologists often linked emotions and values with the phenomenon of the living body in this way. Where Ricœur's advanced the field of hermeneutics was his contribution to understanding how hermeneutical processes intertwine with phenomenology. More than just textual analysis, but also how each self relates to anything outside of the self, this embeds the individual in a socio-cultural lifeworld (Charalambous et al. 2008). Thus, self-meaning and other meaning are principally bound up in existence itself, interpreting phenomenon. For Ricœur, hermeneutics is self-understanding the link between oneself and the symbol—neither thing in themselves, but the dialectical engagement between the two. Ricœur argues that there exists a linguistic productive imagination that generates/regenerates meaning through the power of metaphoricity by way of stating things in novel ways. Consequently, he sees language as containing within itself resources that allow it to be used creatively (Ricoeur 1975; 1984). Ricoeur saw hermeneutics merely as a method of interpreting symbols. However, he subsequently refined hermeneutics into a theory of interpreting discourse, including, but not confined to, the symbols which any discourse contained as a philosophy of language.

3.8.5 Symbolic Interactionism

Symbolic interaction theory analyses society by addressing the subjective meanings that people impose on objects, events, and behaviours. Subjective meanings are given primacy because it is believed that people behave based on what they believe and not

just on what is objectively true. Thus, society is thought to be socially constructed through human interpretation. Symbolic interactionism adds another dimension to the three main IPA philosophical foundations.

The basic notion of symbolic interactionism is that human action and interaction are understandable only through the exchange of meaningful communication or symbols. In this approach, humans are portrayed as acting, as opposed to being acted upon. People interpret one another's behaviours, forming a social bond. Mead (1934), the American philosopher attributed with devising symbolic interactionism, argued that people develop their self-image through interactions with other people. Mead concentrated on the language and other forms of talk that happen between individuals. The '*Self'* — a part of someone's personality involving self-awareness and self-image — originates in social experience. Data in this study would support this idea, particularly in terms of rights to self-determination, that conscience assumptions evolve from upbringing, education, culture, family, and one's own personal experiences, particularly pregnancy-related as much as to do with work-based conscientious objection scenarios.

Cooley (1902) used the term '*looking-glass self'* to convey the idea that a person's knowledge of their self-concept is largely determined by the reaction of others around them. Other people thus act as a mirror so that we can judge ourselves by looking 'in' it. Nickerson (2021) argues that an individual can respond to others' opinions about himself and internalise the opinions and feelings that others have about him. According to Nickerson (2021), it is this central concept of 'self' which allows us to calculate the effects of our actions.

With particular resonance in the data, Gillian's comments (line 325) on how staff are perceived after the 'rainbow for the NHS' campaign would reflect this admission that healthcare professionals are viewed in a positive light: *"You know all workers are on a pillar".* Her comments that a midwife's open expression of disapproval may be disempowering to the woman, are rather more negative, which in essence could be detrimental to the therapeutic relationship between service-user and provider.

Blumer (1969), who tested Mead's ideas, suggested that there are three core principles of symbolic interactionism:

1. **Meaning** - acting and behaving towards other people and things based upon the meaning that have been given to them.

2. **Language** - making symbols and interactions comprehensible to the mind which helps in formulating assumptions by assigning names, associated with whatever features typify the symbol.
3. **Thought** - a process of mentally conversing about the meanings, names, and symbols. Thought includes the imagination: a 'thinking' power to provide an idea even about an unknown thing based on known knowledge (Carter and Fuller 2015).

Given Blumer's premise which states that human beings act on the basis of the meanings of things have for them and that the meaning of such things derives from the social interaction one has with one's fellows, then the theory is tailor-made to any analysis of CO. For example, beliefs about fetal rights to life may be religiously motivated. The *meaning* given to that standpoint may be born of the premise that all life is sacred, and protection of the innocent is a Christian duty, typically expressed or communicated in symbolic *language*. Attitudes to abortion-seeking may be derived from interactions in institutions of worship, hence *thinking* on conscience. In a social and cultural context, situations are defined and characterised according to individuals' subjective meanings. Collins (1994) appreciated the highly individualised, unstructured, and variant nature of interactions. Because meaning is constructed through the interactions between individuals, it cannot be fixed, and can even vary for the same

individual, as time progresses, he suggests. Nowhere is this more apparent than in the contention surrounding case-by-case distinctions.

6. Reflexivity Pit-Stop - Post GETs – My Axiological Position on Abortion

'Practising midwives, practising religion' and 'navigating with a moral compass', several participants link decision-making to the dilemmas of dispensing contraception. As another aspect of sexual and reproductive health policy on which the RC church offers teaching, this raises philosophy questions of abortion versus not conceiving. Different contraceptive methods work in different ways, so objections are rationalised depending on beliefs of when life starts. In terms of my own interpretation of this, scientific ideas build mostly on my professional education around embryology, and further back, public sector secondary curriculums. In the 1980's these were designed to promote contraception as a public health strategy to avert teenage pregnancy. I have gleaned some theological insight into the religious connotations of when life begins from a church background. My upbringing, schooling, and sex ed classes have reinforced my belief in the sanctity of life from the point of fusion (when the sperm meets the ovum). This still pervades as an ethos for me striking a chord when participants mentioned it at data collection. It is Humanitarian concern which motivates me to sympathise with objectors, yet I describe myself as an abortion-defender because I believe in the rights of that life to be valued and above all, the rights of a child to be wanted. Parallel attitudes, particularly towards multiple abortion service-users, get blurred in this regard. *"Some people use it as a form of contraception, which is a no*," suggests Gillian (212) demonstrating her moral judgement. In her take on how easily services are made available, many participants appear to suggest disdain at why services are being accessed so widely, so recurrently and so retrospectively, i.e. once fertilisation has occurred, and the fetus has started developing. After all, anyone can make a mistake. In the data, there appears a commonly vocalised condemnation of trends *"Having frequent terminations for non-medical reasons." (Anna 122-124).* Many participants express disapproval. I myself think that in an age of wholesale supply of contraception, the misnomer of spiralling abortion is a shocking indictment on unmet need. That maternal mortality continues because of unsafe abortion is a tragic, missed opportunity to improve the plight of women. Generally, attitudes to contraception tend to be a watered-down version of more fervent views of abortion. Don't the two go hand in hand? My views impact on the thesis because I believe conscientious objection mostly could be avoided by free access to contraception and its uptake.

3.8 Limitations of Using IPA

Husserl's pursuit of the essence of experience is sometimes criticised as being too abstract (Wagstaff et al. 2014). In response to this, Heidegger, Merleau-Ponty, Gadamer and Schleiermacher addressed shortcomings, updating Husserl's traditional approach, towards a more contemporary hermeneutics. They placed the participant at the centre and ensured participants' accounts are unique, in-depth, and idiographic. By number, as IPA evolved, sample size became smaller, more manageable and by character homogeneous. Therefore, researchers cannot generalise results, some argue. With its focus on small samples, IPA illuminates the whole by focusing on a few. Whilst IPA methodology offers an approach that embraces the importance of individuals' perceived experiences. The value in exploring the idiosyncratic accounts of small samples of 'expert groups' is sometimes criticised for being elitist (Oxley 2016). In this study, it could be criticised as being exclusive, since it represents only midwives, not other occupational groups, whose moral worth is of equal standing.

One could question methodical rigour, what if the Hermeneutic is inflicted by bias, or the sense and meaning making, skewwhiff or misinterpreted? For example, Tuffour (2017) claims undue emphasis could be given to opinion rather than meaning making. As two different researchers could come up with different interpretations, IPA is fundamentally a subjective research method, he maintains. Critics of IPA suggest that it is unscientific, lacking a complex subjectivity and displaying a promiscuous epistemology (Dennison 2019). Giorgi (2010) suggests IPA is unscientific due to a lack of a clear method (Giorgi, 2010). Smith (2010) answers this criticism, urging that within an IPA frame, it is the interpretative processes that are pivotal. Intuitive insights articulated by the researcher rather than adherence to fixed steps are key (Smith, 2010), yet in this study, the ideas are innovative, IPA is new departure. Although conducted by a novice, the study is original in many regards.

IPA opens up new avenues of research. Close examination and metaphorically shining a light on a small area, may lead to the illumination of the whole in new exploration and discovery. Even though the approach can be beneficial in acquiring a large amount of data, the qualitative nature of IPA makes it difficult to analyse a particular piece of empirical information. Causal relations are not examined – as such, IPA does not explain why certain experiences happen, only the participants' interpretation of that.

IPA is a lens (not a mirror). It enhances reflexive awareness, makes clearer phenomenon, and allows the voice of others to be heard (Dennison 2019). This relies heavily on exercising judgment. It calls for adequate reflexivity and honest, self-evaluation which can weaken the strength of the study if itself is inadequate, introducing further, potential bias. No researcher exists in a microcosm, nor do any of the participants – we are all products of our experience – each has pre-understandings with distinct "Booming clangs and whispering ghosts… echoes in IPA research" (Goldspink and Engward 2018: 1). IPA methodology can easily be mistaken for a descriptive one, epitomised by the popular mantra of Larkin et al. (2006: 103), "IPA is easy to do badly...difficult to do well". The role of language as a way of constructing reality, both descriptively and analytically, places a heavy responsibility on the participant "to think, talk and be heard" (Reid et al. 2005: 22). To drive comprehension, the participant's role in describing, exploring, explaining is pivotal. This is the essence of sense and meaning making. Some commentators argue this burdens the participant and may only reflect opinions of those who articulate ideas, communicate well, favouring the more linguistically able (Wagstaff et al. 2014). IPA appeals to those with awareness and consciousness. This study represents clinicians. Not everyone is a natural philosopher or has insight – may want questions answers rather than provide an answer, through sense and meaning-making. Van Manen (2007: 13) suggests phenomenology must have practical value, and draws on Heidegger's warning that phenomenology,

"Never makes things easier, but only more difficult" (2000: 12).

He agrees with those who feel that phenomenology lacks effectiveness or utility if one hopes to do something practically useful with it: "Nothing comes" of philosophy; "you can't do anything with it."

This is where this study hopes to be rooted in theory, in the model and of benefit to clinicians and, in fact, anyone facing an ethical dilemma because it provides tools to support systematic decision-making.

Meticulous implementation of double hermeneutics principles can be tricky without cultivation of an "approachable, non-critical, unthreatening attitude" (Nolan 2011: 1). Data collection (usually by semi-structured interviews) can be open to directives, improper power imbalances, and this renders the findings unreliable. This resonates with the concept of Dasein where being-in-the-world is explored through "being with others" (Horrigan-Kelly, Miller, & Dowling 2016, p.3). Dasein can be understood as a

relational being where we exist alongside others. Within this context, the self is shaped through dialogical interactions with others in the world. As Frank (2005) claims, a voice is not unique but embraces the words of others. Therefore, an exchange of ideas between dialogical methods (Sullivan, 2012) and IPA could be beneficial. This may seem counterintuitive particularly since IPA is inductive whilst dialogical methods are described as theoretical in analytical approach (Madill et al. 2018).

The experience of one's own body, or one's lived or living body, has been an important motif in many French philosophers of the 20th century. Merleau-Ponty talks of "Making phenomenology one's own". Similarly, current 21st century IPA is "flirtations with other methodologies are described as being advantageous in that they encourage gene flow and a productive cross fertilisation of ideas", suggests Dennison (2019: 2). So doesn't this make it just confusing and convoluted? critics could ponder. Giorgi attempts to explain the reasons for this,

"When the modifications are not consistent it is usually because the claim is based on the failure to distinguish between phenomenology as a philosophy and phenomenology as a theory of science." (Giorgi 2010: 3)

As a growing area of research (Reid et al. 2005; Tuffour 2017; Smith 2011; Smith et al. 2022), IPA is used in an increasingly diverse scope incorporating ever more comprehensive research questions (Tuffour 2017). For all this development, its relative newness could be viewed as a strength in novel, exploratory studies, but that may entail a degree of uncertainty or lack of structure if the research is pioneering and untested. Smith (2011) does provide guidance on how to do IPA well, in a paper which states the biggest specific area of research within IPA is illness experience, forming nearly a quarter of the corpus. The shortcoming here in this subject, is that pregnancy is not necessarily a disease, and service-users generally are not sick.

3.9 Conclusion to Methodology Section

The qualitative paradigm of this study has thus been shown to encompass the methodological philosophy of Husserl's 'God's eye' phenomenological perspective and Heideggerian Hermeneutics. We have looked at the ontology of the study and the epistemological stance of the thesis assumes that the researcher is an integral part of the interpretation. The underpinning philosophical foundations – phenomenology, hermeneutics and idiography - have been widened to incorporate symbolic interactionism to explore a linguistic dimension to the study. IPA principles based on

Smith, Flowers, and Larkin's (2022) model 'make the IPA one's own', as expounded by Smith et al. (2022: **3**) but keep the participant at the heart of the study as 'the universe of exploration'. To achieve this, now I will examine how the method of data collection, comprising semi-structured interview methods will look at a CO decision-making worldview.

7. Reflexivity Pit-Stop – My Overseas Experience and Backstreet Abortion

As a practitioner my career has followed an atypical trajectory with experience in women's health care in some of the most challenging areas of the world, where extreme poverty blights pregnancy and childbirth. This materialises in some of the highest maternal mortality rates, including abortion-related deaths which have left indelible impressions about what constitutes care. My previous research activity includes taking part in verbal autopsy case study research and audit of emergency obstetric care. In the conduct of the research, I was acutely aware because of this experience of the ethical need for confidentiality, trust and rapport building at interview. The importance of non-directivity and an unbiased, non-judgemental approach to interpretation was driven home. This professional background, above all else shapes my opinions of CO and women's rights in general. An insider view is afforded by the fact that I have both taken part in abortion, in a student capacity and expressed CO rights, once a little more insight had been gained. My axiological stance is that in the wrong hands CO can be painful and do more harm than good, thus as such my positionality is that CO should be properly regulated, uniform and non-discriminatory. This particularly impacted on analysis of the data because I empathised with midwives who had more pro-choice leaning. Like the participants in this study, I maintain woman-centredness but wholly support the employment right of individuals to CO – this motivates me to find well-balanced recommendations and is perhaps mirrored in that I see the primary duty to be to as a midwife, who practises their religion, not a believer practising midwifery.

Chapter 4 – Method

4.1 Study Design

Literature on the topic appears to present freedom of conscience as a fait accompli, with little or no examination of the mechanisms of how an objection decision may be arrived at. This feature of the topic fit with the methodology because it applied rigour to a subjective, reflective, and introspective, lived experience of moral reasoning. IPA proved a vehicle for a qualitative PhD study, in which I conducted online, audio-recorded, semi-structured interviews, lasting approximately 1 hour amongst 15 midwives. Data was analysed using the Smith, Flowers and Larkin (2022) IPA model.

4.2 Justification for the Approach

Semi-structured interview aims to facilitate naturally flowing, open conversation (albeit as a mostly participant-driven, one-to-one research tool). It is thus well-suited to IPA in cognate social science disciplines (Cudjoe 2022; Smith 2011). Semi-structured interview is widely viewed as the exemplary, ultimate measurement instrument since interviews are more easily managed, affording participants “space to think and be heard” (Cudjoe 2022: 2). This is key to the personal nature underlying IPA. The idiographic aspects of IPA are well described in corpus detail on case-level studies, especially in health (Smith 2011). As the most frequently used way of eliciting an accurate data source in qualitative inquiry (De Jonckheere and Vaughn 2019) advantages of semi-structured interviews include flexibility, yet rigour, in open-ended data collection. With its accent on inter-personal relationships, engagement and skilful facilitation, semi-structured interview techniques call for respectful rapport-building, well suited to the kind of intimate discussion that conscientious objection, decision-making and workplace dilemmas call for. De Jonckheere and Vaughn (2019) offer useful advice on dealing with sensitive health topics, including determining the purpose, respectful conduct, and trustworthiness, amongst others (Gil-Rodriguez 2022; Pietkiewicz and Smith (2014). Using a semi-structured interview method fits comfortably with IPA because it affords ample opportunity for the participant to steer the topic and drive the arguments, reducing the potential for bias, enhancing sense, and meaning making. Conducting interviews in naturalistic settings also ensures data is truly idiographic (Pietkiewicz and Smith 2014). In this study interviews were conducted online at home, a ‘safe’ place of the participants’ choosing, reconfiguring power dynamics, and affording privacy.

4.3 Limitations of Using Semi-structured Interviews as a Method

Strengths of using semi-structured interviews far outweigh the weaknesses, which even so, need to be considered. There is a lack of anonymity with interviews, which may be off-putting, especially if participants do not easily engage in research (Braun and Clarke 2013). Open-ended questions do indeed produce data in depth rather than breadth, expanding horizons of understanding but this may be time-consuming. The potential to steer the discussion, prompting possible interviewer led bias remains a factor to be considered. The flexibility that semi-structured interviews bring, may be seen as a flaw if this affects reliability. The possibility of bias through loss of data caused by language barriers is suggested by Kakilla (2021) but this was not really an issue as all participants were English-speaking. Furthermore, semi-structured interviews may be problematic without the right amount of training to conduct the interview properly to consider power imbalances which are overcome by supervised, audited use of IPA – it is expounded for its ease for the novice researcher (Rettie and Emiliussen 2019; Smith 2022) and made more transparent in its process by the Smith, Flowers, and Larkin model, which Rettie and Emiliussen formerly called for.

4.4 Planning the Study and Ethical Approval

Ethical approval was achieved (UREC registration number 21/NAH/013) as per LJMU procedures (Appendix 1). This reiterated the valid purpose of conducting the study, its potential for contributing to safer maternity practices and clearly communicated the rationale for the choice of methodology and techniques in doing so.

Recruiting professional participants with knowledge of the research topic minimised risks, ensured suitability and representativeness. In short, asking the right questions, of the right people, in the right way. Midwives, at pre-testing potentially, were known to the applicant through professional association but participation was voluntary, confidential and the researcher is not in any position of authority. No pressure was exerted in consent-taking or at any other point in the research process. All proffered feedback that this was a worthy and interesting study, that reached out within the midwifery field on a topic of much contention, reassured me of participants' willingness. Participants were free to withdraw up until the data analysis stage. In addition to a written consent form (Appendix 4), I further confirmed consent when I conducted interviews online at a time and place of participants' choosing.

I answered queries throughout the research and protected the welfare of participants through strict adherence to ethical approval such as providing contact details of a trained counsellor/psychologist, who agreed to support participants in the research. I reassured participants of the use of pseudonyms and ensured all contact details were confidential to the researcher and non-identifiable to anyone else at any point. Engagement with participants from the offset of interviews helped to establish trusting relations and descriptive contextualization I anonymised the data collected by removing all identifiers (such as place names and career history) including those of cases cited.

To maintain professionalism three main encounters were approved – introductions, including taking consent, interview and follow – up, in which participants were asked to review transcripts, a simple form of respondent validation. In IPA, there are its own phenomenological and Hermeneutic challenges in doing this (see Section 4.8.1 on 'Verifying the Data'). Data was confidential and data protected – recorded files being shared only as designated and as ethically approved. Audio recording devices remain password protected, and all data was transferred to secure storage as soon as possible: LJMU One drive and deleted from the audio device. Transcripts were only seen by the applicant and PhD supervisors in accordance with GDPR data storage recommendations.

4.5 Inclusion/Exclusion Criteria

All UK based Nursing and Midwifery Council registered midwives were included in the study regardless of conscientious objection, ideological position in order to ensure a full spectrum of views. A number of neonatal staff were approached but did not opt to be included in the study. This afforded an opportunity for newly qualified midwives and retirees (within 5 years) to take part. I was curious about the male perspective, and delayed analysis until a participant volunteered to provide an alternative view.

I excluded individuals working in healthcare settings in a student capacity, using a 21-years old upwards age range because they were less likely to have encountered freedom of conscience or participated in abortion procedures, in clinical settings, given the structure of their curriculum. Any participants with a serious mental health condition, who may experience emotional harm when discussing abortion were not encouraged to apply. I protected participants by assuring their participation was voluntary. The realisation of full informed consent and respect for persons was maintained as I explained participants were free to withdraw without explanation until the stage when

data analysis was completed. The study centred on participants in England and Wales due to the current configuration of services in Northern Ireland and Scotland.

4.6 Recruitment

In this study, participants were chosen by purposive sampling from three English sites because of their expertise, with lived experience of what I wanted to explore. For this reason, purposive sampling is known as also known as judgment, selective or subjective sampling, characterised by being representative, cost effective and using sound judgement (Black 2010). To this end, I generated debate around conscientious objection amongst colleagues, interested in the PhD study. I put up a poster/flyer (Appendix 2) and shared on social media (LinkedIn and Facebook). The Royal College of Midwives also agreed to advertise on their research network 2020-2022 (www.rcm.org.uk/promoting/education-hub/research-and-funding). The IPA group by coincidence, led to recruitment of a further professional colleague – evidence to the benefits of snowballing sampling. Some participants came forward who self-identified themselves as having some insight into conscientious objection or a particular perspective on decision-making, lived experience of conscientious objection, strong conviction they wanted to share or a view they wanted to voice.

4.7 Sampling Advantages and Limitations

The non-probability sample was only homogeneous to the extent that the people selected were likely to have a similar experience of the phenomenon within a professional group but were still different individuals with alternative views. Whilst this may alert us to the possibility of selection bias, there are still many benefits to purposive sampling, the most adopted sampling by IPA researchers, Noon (2018) advises. It is accepted that purposive sampling ensures the study holds relevance and personal significance to respondents and enables investigators to capture detail on a specific group of individuals who have experienced a particular phenomenon. Errors in judgment by the researcher, a low level of reliability and bias are among the disadvantages of using purposive sampling, however.

In the course of conducting the study, it became clear that there was a great deal of ambiguity. Generally, data lacked clarity about what constituted conscientious objection and rights in the workplace. There was uncertainty about its manifestation and the frequency of conscientious objection encounters. Expanding horizons of understanding, therefore, involved widening the recruitment to fifteen from the planned and

approximated six. The pros and cons of this research decision are deliberated in section 4.8 on sample size and its justification.

One key marker for assessing the quality of qualitative research is the selection criteria used to recruit study participants (Stenfors et al. 2020). Ensuring credible, plausible, and trustworthy research findings is an alignment between theory, the research questions, data collection/analysis and results. Sampling strategies, the depth and volume of data and the analytical steps ought to be appropriate within that framework.

After purposive recruitment mostly through professional networks, I disseminated further information on the study by sending a follow-up 'Participant Information Sheet' (Appendix 3) via e mail, at which point participants confirmed their willingness to be included and confirmed consent. I pilot-tested the interview schedule (Appendix 5) with one initial midwife in October 2021. Pilot testing benefitted me by confidence-building with the interview technique, active listening, and technical ease. I became more conversant in iterative questioning on the sensitive issue of conscientious objection which helped ensure transparency.

4.8 Sample Size and Its Justification

Ideal sample size in IPA is a topic of much discussion, sufficiency would depend on the quality of the data (Smith, Flowers, and Larkin 2009; Smith 2022). It is argued this fewer number allows opportunity to gain adequate insight at deeper levels, without becoming too convoluted or difficult to manage. Smith, Flowers and Larkin (2009: 56) suggest that in IPA research,

"There is no right answer to the question of...sample size".

Clarke (2010) stipulated that three is the default sample size for undergraduate or Masters-level IPA study, whereas four to ten is advised for professional doctorates. In traditional phenomenological studies, Coyle (2014) noted that the average sample size was between one and twelve.

Remaining dedicated to each individual case at the same time as exploring the multi-faceted subject matter with sufficient profundity was a precarious balance to tread. This apparent immensity was achieved, I believe only by employing NVivo (albeit not for analysis but for data management). Some conversations produced more lucrative data than others, though all participants contributed a richly yielded insight with thought-provoking sense and meaning making. A numerical sample of fifteen allowed me to

commit to a thorough and in-depth analysis of each case, which in turn enabled me to highlight the individuality of particular experiences – a key principle of IPA.

Generally, it is assumed that it is difficult to do a good IPA with lots of people because of the manageability of sample size and desirability for 'bandwidth'. By that it is meant a focus on depth rather than breadth of analysis, in a manner that Smith et al. (2009) call "peeling back an onion". But there is also a more fundamental methodological question about homogeneity. IPA uses homogeneous samples because this enables the analysis of convergence and divergence between cases to yield insights about potentially essential characteristics of the phenomenon as well as the variety of ways in which the phenomenon can be experienced. What is meant here is homogeneity in terms of the phenomenon that participants have experienced, not necessarily together, rather than homogeneity in terms of pure demographic or occupational information. There the similarity ceases. Indeed, in this study, the only resounding commonality was that all were qualified midwives: a professional group, but of various ranks and accompanying managerial responsibilities.

More importantly, with regard to conscientious objection (a topic which transcends occupational boundaries) participants lived experiences were unique and iteratively explored. In the blurred line between professional and personal personae, their views and axiological positions all varied. The contrasting sense-making and meaning-making produced very broad accounts, and different, ideologically reasoned conclusions about the moral implications of freedom of conscience. Data gave insight into a kaleidoscope of pre-understandings, as eclectic a mix of perspectives, as diverse as the participants themselves. Their backgrounds, and personal specifications were all very cosmopolitan and multi-cultured. Remember, IPA uses a lens, not a mirror, so the precept was to look at conscientious objection through the eyes of different ethical decision-makers.

Gender would be a big contributing factor to the experience but although non-homogenous in this regard, it was deemed fitting on this most burning of women's issues, to gain a male perspective, since one practitioner's ethical value is as worthy as the next. As a conviction or ideology, rather than a freedom of conscience movement with consensus. The important thing then is to serve the idiographic commitment to examine each case on its own terms and in its own right. Cultural factors, age and the length of time qualified all could have impacted too. The much-sought diversity and inclusivity of the sample adheres itself to de Visser et al. (2024: 3) who maintain,

“Larger IPA studies do not simply increase the sample size, but instead increase the number of homogeneous groups.”

However, this study was treated as a single sample and a single study. Although it may not seem important in what order the cases were delved into, therefore, analysis was undertaken consecutively, irrespective of whether the midwife was ultimately an objector or not.

As a concept conscience is introspective, and essentially inward-looking, but beliefs around conscientious objection, though privately held, can sometimes breach societal acceptance of it. By extending into a public space, the measure of the phenomenon for researchers may be more easily located if the researcher is compatible and accepted as a homogenous part of the group, one could argue.

Even within healthcare professional groups, some midwives may have not encountered freedom of conscience, or themselves conscientiously objected, (in Heidegger terminology – the self-showing being of beings or thing in itself) but all participants had lived experience of moral reasoning and ethical dilemmas through a decision-making process on which they reflected. This is most importantly what the research was trying to capture: a sense of how some midwives decide to participate in abortion, whilst others do not (as well as why). IPA assisted in exploring idiographic mechanisms to explain how each of them arrived at their views. Having lived experience of another’s objection was still considered valid and legitimate in terms of the inclusion/exclusion criteria, because that too provoked ethical dilemma when working in teams, a reflection vital to our consciousness. Those disagreement dilemmas facilitated the interpretation of meaning in a Gadamerian-type wider ‘horizons of understanding’ (Suddick et al. 2020). Indeed, the study built on these multi-perspectives of McInally and Gray-Bunton (2021) discussed earlier.

4.9 Homogeneity and Participant Characteristics

A relatively homogeneous research population is also desirable in IPA research (Noon 2018; Quinn and Clare 2008; Smith 2009; Smith et al. 2022). In this study, tailored IPA orientated research objectives are aimed at one occupational entity (midwives) on a specific interest to respondents (decision-making around CO). Unique issues to participants’ sense and meaning generate incidental ideas according to expertise. Teddlie and Yu (2007) suggest that it is this “trade off” between greater depth and breadth that distinguishes purposive sampling from other types of accessing

knowledgeable participants. Rather than generalisable findings, in IPA, each dataset is generated in different voices. More recently the intersubjective and relational aspects of IPA, are being realised, suggest McInally and Gray-Bunton (2021). This gives IPA the advantage of a multi-perspective design, especially giving voice to multiple participants, or employing multiple researchers (McInally and Gray-Bunton 2021; Montague et al. 2020). It is precisely its idiography which makes IPA particularly useful for understanding under researched phenomena or perspectives (Peat et al. 2019).

In sofaras IPA is essentially an idiographic methodology which incorporates how a given person gives meaning to a given situation at a given time in a given context, IPA does not realise generalisable findings. Nonetheless, in qualitative studies transferability may still occur. In conscientious objection particularly, participants' unique qualities may have bearing on moral reasoning and ethical decision-making. Axiological position on abortion is known to be influenced by a number of factors, (upbringing being the most significant of these causal factors, as shown in section 2.3) and these pre-understandings hold weight here. Participants originated from a variety of backgrounds, were of diverse ethnicities, cultural and gender identities, differed in religious beliefs and observance, were of a range of age groups and had no set educational schooling paths. At introductions, all furnished details of dissimilar histories. These demographic features framed the reference to the lived experience being recounted, as much, (if not more), than their professional experience. Only certain participants combined nursing and midwifery roles and/or had undertaken a programme of nurse education, but all were qualified midwives. Post-registration, after completing preceptorship, one participant worked in abortion provision. Their career trajectories were discussed at length to contextualise how objection was encountered, how they gave credence to the concept, how they judged moral rights and wrongs and what reflective opportunities had arisen. All were NHS trained, based in the UK, in education, management and firsthand care provision. Although predominantly white British, one participant was of Irish origin, one of Asian heritage, and another was born in the Caribbean. Participants' ages ranged from mid-twenties to mid-fifties. Observations were made through a global lens, but only a handful had overseas work experience.

These contrasts became most evidently plain in data analysis, when convergence and divergence highlighted sometimes atypical views centring on sexual and reproductive health, contraception, women's status, human rights and the midwives' role in facilitating service-users' needs. Getting to grips with meaty concepts affecting care made for interesting comparisons in terms of the research's IPA-ness, as each participant

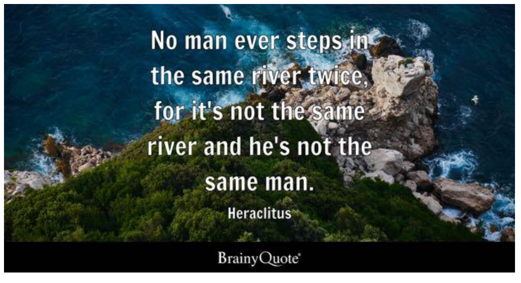
attributed sense and meaning from their individual perspective. Whilst attempts were made to ensure participants' homogeneity, this evolved only as a singular professional group at the same time as an assortment of managerial responsibilities. The insight given forth was substantially different in many regards. Midwives defined conscientious objection in non-conformed ways so their perspectives on what forms participation takes showed discrepancies. This gave rise to the conceptual model. Similarly, the framework (detailed in table 8) was born of the divergent moral and thought processes.

4.10 Data Collection

Use of an interview guide, a list of proposed ideas for data collection, with clear parameters reduced bias, (whether conscious or unconscious) ensured research questions were addressed with consistency/confirmability. This meant data reflected the characteristics of participants, less the researcher. I took notes, or memos, on the guide during interviews to record investigation of a particular reflection, concept, theme, or problem which helped capture emerging issues ad verbatim and formed the basis of further field notes.

Like all qualitative research, IPA studies avoid any attempt to build or pre-determine hypotheses, so this study fitted well with IPA methodology because the phenomenon explored psychology unique to the participant. IPA methodology is most suitable to find out how individuals make sense of their personal or social world as Smith and Osborn (2007) argue, especially concerned with complexity, process, or novel phenomenon. Thus, I framed the schedule broadly with no leading assumptions. Facilitating storytelling, to elicit free, uncategorised responses, I used the schedule, as an aide memoire rather than a directive. Whilst probing, questions tended to be exploratory in no set order. In collecting data, I followed participants' interests or concerns in an inductive and iterative way (that is to say, affording opportunity to give examples, make sense of them and interpret findings to devise recommendations that are participant-driven).

4.11 Verifying the Data



As stated earlier, IPA aims to offer Hermeneutic insights into how a given person, in a given context, making sense, and meaning of a given situation. Heidegger developed this idea in his work 'Being and Time' reaffirming the temporality of experience. We are reminded of Heraclitus' premise. The Ancient Greek

(544-483 B.C.) philosophised that, ‘No man ever steps in the same river twice, for it is not the same river and he is not the same man’ *(quoted by Cratylus* 402a = DK22A6 in the in the Diels-Kranz collection of Pre-Socratic sources (Graham 1997).

In his theory of knowledge, Heraclitus believed the great majority of human beings are lacking understanding, rejecting the rule of the masses with an aristocratic disdain in favour of government by a few wise men. Striving for harmony and justice from strife, he maintained the underlying law of nature also manifests itself as a moral law for human beings. According to both Plato and Aristotle, Heraclitus held extreme views that led to logical incoherence. For he held that (1) everything is constantly adapting or evolving and (2) opposite things are identical, so that (3) everything is and is not at the same time. The central ideas of Heraclitus' philosophy are the unity of opposites and the concept of change. He also saw harmony and justice in strife. He viewed the world as constantly in flux, always "becoming" but never "being".

To this end, member checking did not form part of the study design, per se. In other qualitative methodologies, member checking is often mentioned as part of respondent validation techniques (Birt et al. 2016; De Loyola González-Salgado et al. 2022), but it is not so relevant to the idiographic focus of IPA. As a formality, member checking was excluded as a part of the study design along the same lines of argument as Heraclitus, that data captures only a passing glimpse, a snapshot of the lived experience.

Notwithstanding, after transcription (an example of which is in Appendix 13), I provided a copy for the participant, which they were at liberty to comment on. As an alternative means of verifying the data, participants were afforded an opportunity to check for appropriateness, correct possible inaccuracies and, at their own discretion, clarify detailed assertions. I asked via e mail,

- “Does this match your experience?”
- “Is there anything you want to change?” and
- “Do you want to add anything?”

Giving participants a chance to verify their statements and fill in any gaps from earlier interviews, enhanced the superiority of their accounts – measures which promote trustworthiness according to Bailey (2008). The quality of participants’ data was enriched by their own reflection and interpretation after the semi-structured interviews. It added to the sense and meaning making, an expression of the Double Hermeneutic and interpretative elements of IPA. This dual co-production of knowledge, generating ideas

and concepts from participants themselves (Redman et al. 2021) is another rationale for using IPA to inspire new ideas (Deterding and Waters 2018).

As part of understanding it is not only the researcher's interpretation of the data that is sought in the research method, then the data becomes open to a more collaborative, participatory, and negotiated approach. Co-inquiry is thus an important attribute of sense and meaning-making processes. Sometimes the meaning-making process may travel away from the original data as new insights come to light. The respondent validation undertaken here represents a step towards researcher anchoring these insights in evidence. Carlson (2010) discusses reflexivity, triangulation, and trustworthiness in the context of using member-checking “lenses” (the self – the researcher, the participants, and the external reader) (Carlson 2010: 1105). Common procedures for increasing trustworthiness are offered up in her work with several recommendations for avoiding the setting and triggering of member checking traps, particularly in IPA regard. For example, sometimes member checking is done at a few key points throughout the research process with some scholars recommending it be done continuously (Doyle 2007). Her work to conduct in-depth and member checking interviews were informed by Heidegger's interpretative hermeneutic phenomenology and in the same way, so it is in this study. The verification undertaken in this study, however, was a single event that took place only of transcripts rather than with early interpretations.

Phenomenologists also take Heraclitus’ quote to refer to the ordinariness of the lifeworld where can oft become phenomenological. The researcher derives insight by employing curiosity to listen to people narrating their stories in their own natural settings to identify how their experiences and behaviours are shaped by the context of their social, cultural, economic, and historical worlds (Tuffour 2017). Tuffour continues,

“Hermeneutic theorists utilise their subjective expressions to reconstruct original meanings during textual interpretation. Hermeneutic phenomenology therefore embraces the literary and poetic aesthetic application of language that emanates from the process and product of research (Tuffour 2017: 4).

4.12 Transcription

Conducting interviews using Teams’ rather than face to face afforded an opportunity for interviews in flexible locations of the participants’ choosing as advocated in the literature (Self 2021) and ethically approved (see Appendix 1). All participants opted for this at their home (away from workplace settings). This was presumably because of competing

demands of the Maternity workload. Given the taboos and sensitivity of the subject, the safe setting was conducive to an opportunity for open discussion about dilemmas and ethical decision-making.

Data was confidential and data protected – recorded files being shared only as designated and as ethically approved. With consent, interviews were audio-taped to afford lightening-speed recording of responses and foster attentiveness to the conversation, full of prosodic gestures and phonological cues. These were visualised and documented as part of the analysis to show the emphasis attributed by the participant to their statements. This ensured the data is reliable and trustworthy, as well as the meaning, appropriately communicated (Alase 2017; Self 2021). The academic endeavour to catch every detail, intricately first-time round with accuracy and fluency is the heart of expression. How best to achieve the conveyance of the participant's message, to make the content of the data immediately actionable, using prosodic gesture, was considered a matter of two main options: human and/or automatic. The former, typed by self, as the researcher, the latter, by use of mechanical transcription.

Despite appearing a straightforward technical task, transcribing can actually be regarded as one of the first analytical steps – which involves making judgments, for example, about choosing how much detail to include (Charlick et al. 2016. Whether or not the researcher's role should include ad verbatim transcription is a matter of much controversy in the literature, striking a balance between authentic representation and researcher interpretation may potentially introduce some distortions. In this study, I opted for using memos and field notes when the material was still fresh, the first step towards accurate manual transcription, rather than automated. Skilful manual transcription, however, does call for a certain respect for dealing with responses as scientific evidence (Smith et al. 2022). Cost effectiveness, a high degree of consistency and keeping data as close to the original as possible are amongst the main advantages of researcher-transcription. On the other hand, automated transcription may mechanically eliminate errors caused by fatigue and distraction, but this proved more in theory than practice. Communication, particularly in healthcare, is often full of jargon and conversations are full of pitch variations, colloquialisms, and slang, which included overlapping and dialectic speech (errors like 'curd' rather than 'cared' arose for example). Manual transcription seemed wholly more responsive and sensitive to these features. Verbatim transcription (including expressions of emotion, such as laughing and stuttering) was deemed the most appropriate (an example of this is provided in the transcription example in Appendix 13). Ultimately this fostered a sense of not only *what*

is said but shows *how* it is said. Intelligent and edited verbatim techniques (which look to fix broken sentences, make sense of long-winded paragraphs, and omit fillers ("you know", "if you get what I mean?", "am I right?") was disregarded because of the desire for authenticity and research rigour. However, pauses and missed audio were demarcated and emphasis was added using italics. This made it easier to analyse using the following model.

4.13 Theoretical Model of the Thesis: Smith, Flowers, and Larkin (2022)

The work of Smith, Flowers, and Larkin (2009) is the seminal IPA text. The potential for its use in midwifery research is elaborated on by researchers (Charalambous et al. 2008; Roberts 2013; Walsh-Gallagher et al. 2012). Outlining the theoretical foundation for a method of qualitative inquiry with growing impact, the first edition discusses how phenomenology, Hermeneutics and idiography have been taken up by IPA.

According to Smith, Flowers, and Larkin (2009: 82), immersing oneself in the data forms the basis of receptiveness to the participants' original message. Described as a "quick and dirty" technique (Smith 2021), overwhelming ideas and possible connections may result from reduction and synopsis. It is ideal to reduce the level of this 'noise' (pre-understandings and distractions within the researcher which may detract from the meaning) by active engagement with the data, they suggest. In doing so, participants' generic life stories, implicit meanings and insightful explanations often embedded, are less likely to be inadvertently missed or misinterpreted.

Smith, Flowers, and Larkin's second edition (2022) features an even more contemporary way of conducting analysis in three main categories for dealing with data: exploratory notes and personal experiential themes (or PETs) which then become group experiential themes (GETs). Making connections still occurs, as does clustering ideas to generate stronger themes, but the purpose is to keep data grounded, participant-driven and rigorously true to the original. The new departure appears to answer criticism that IPA makes only intra-connections within each account rather than inter-connections, between them. Looking at patterns across cases helps the analysis move to a more theoretical level - an umbrella view (Smith 2021). Smith and Nizza (2021) and Smith et al. (2022) advise employing the new terminology from the start if you are new to IPA.

4.13.1 Initial Exploratory Noting

The free textual analysis that comes with initial noting, is the first step in which actual data gets to be interpreted, rather than it evolving or emerging (implying an active role for the researcher as analyst) (Smith et al. 2022). This was conducted after data collection. Superficial reading converts raw data to the assignment of 'memos'. Comments (descriptive, linguistic, and conceptual) are integral to attempts to further immerse in the lifeworld of the participant. From the content's language, as it is expressed in phrases, intonations, and rhythms, what matters to the participant is more greatly understood by refining the commentary, vocalising implicit meanings, and amplifying the silent voice.

4.13.2 Emergent Personal Experiential Themes

Now familiar with the data, the focus is on the analyst developing emergent case-level PETs, which ebb and flow both through and within the data. This is an interesting word choice, unlike Braun and Clarke (2013) who criticise the term 'emerge' based on the premise that research is exploratory. Indeed IPA, by very nature is interpretative, conceptualised and iterative rather than an entity.

4.13.3 Devising Group Experiential Themes

Identifying cross-level patterns in these emergent themes is known as 'abstraction', which Smith, Flowers, and Larkin (2009: 96) suggest,

"Involves putting like with like and developing a new name for the cluster".

This may appear uncharacteristically quantitative in nature but does give an indication of the theme's significance. Organising the order that themes appear in the data, known as the themes' 'function,' is also important because it reflects, perhaps, those more burning issues that the participant wishes to prioritise, interpreted en masse, and presented as ideas in a logical sequence.

4.14 The Practice of Data Analysis

Once data was collected, transcribed, anonymized and collated, the process of word by word, line by line analysis began in accordance with the IPA principles of Smith, Flowers, and Larkin's (2022) model. This involved a systematic and logical process of exploratory noting, responding to the data, devising personal experiential themes, and

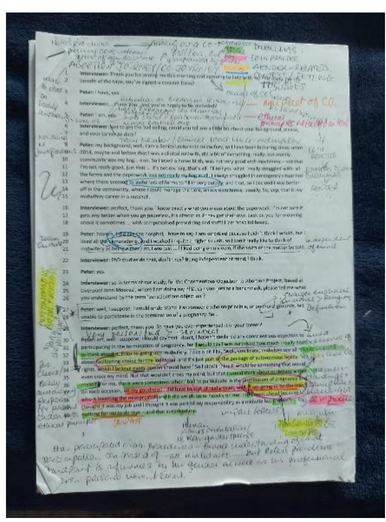
interpreting findings. Then areas of convergence and divergence were examined cross level to devise group experiential themes. Each with greater depth, this involved scouring the data four consecutive times:

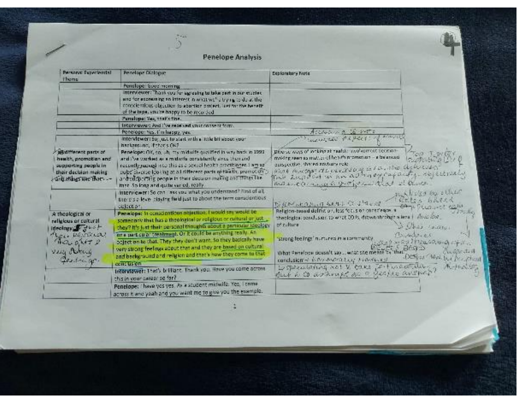
1. Exploring meaning, language and thought (as suggested by Blumer's (1969) symbolic interactionist theory). This afforded the opportunity to illuminate from each perspective of the raw data: what the participants said (with prosodic emphasis).
2. Examining what participants omitted to say (identifying unfinished comment and speculating on other potential argument - what was intimated, avoided or might have been added?).
3. Giving sense and meaning-making (how participants evaluated the significance of their insight, reasoned their own lived experience and its causality – what importance was apportioned to their observations?).
4. Interpreting participant comments (centring on my sense and meaning making – what added layer of insight did theory provide?).

Interpretation of ideas was managed in two ways:

a) tabular form, manually on a word document using coloured post-it notes and penned linguistic, conceptual and metaphorical codes with post-it notes under the headings: participant dialogue, exploratory notes, and PET (see figure 10 below);

<u>Figure 10: Field Notes and First Draft Colour-Coded Exploratory Noting</u>




Penelope Analysis

b) employing NVivo software (the rationale for using this was more in terms of data storage given the vast amount, see section 4.19). Rigour was ensured by close case

level audit to ensure the participants' voice was truly being interpreted. The comparison that led to the 'Model of Definition' (section 7.7.1 explained in section 7.7), the 'Spectrum of CO Views' (Appendix 10, described in section 7.11) and the 'Pen Portrait Thumbnail Summaries' (Appendix 12) was a natural progression. The ideation was formed by the process of convergence and divergence - noting that there were distinct similarities in the way conscientious objection was defined, viewed, recollected, and made sense of. The lived experience was unique, indeed, yes, yet there existed commonalities more than those born from being a homogenous group. These were striking as a strength of conviction, heavily reliant on what midwives classed as participation in abortion (and thereby abstaining from participation, known here as conscientious objection). The consensus being highlighted in the resume that being formed showed conscientious objection was conditional – but depending on what? This led to a review of the interview schedule and data responses which evolved into a spectrum and schools of thought. The conceptualisation represented in this 'Model of CO Definition' was guided by the double hermeneutic, now discussed.

4.15 The Double Hermeneutic Approach

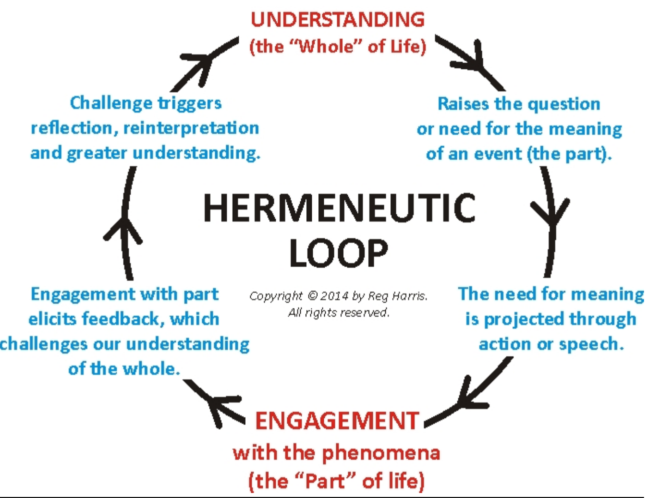
If phenomenology uncovers phenomenon, Hermeneutics gives it meaning and through a wider angled lens, in the double hermeneutic approach, defining then refining interpretation. The concept of the hermeneutic loop operates at several levels, which move back and forth in an iterative rather than linear way, expanding horizons of understanding. This represents a criterion for demarcating the human/social from the natural sciences, one in which reflection is triggered, contextualised and constantly reassessed. Because it deals with living people, who react and interact with and in the research environment, knowledge is co-produced with a dynamism typical of interpretation.

Pringle et al. (2011) sum up how the qualitative approach enables the researcher to bear witness to emergent themes, as well as become an active participant in their sense and meaning-making discovery: the essence of interpretation is by two-way negotiation. Mutuality promotes shared decision-making and makes dualist conclusions. At the same time, pluralism gives voice to the participant (Larkin, Watts, and Clifton 2006), so important for the marginalised objector.

The following diagram highlights the dynamism of the meaning-making aspects of double hermeneutic principles. In the interpretation and interaction between the researcher and research participants, hand in hand, the effect of the double hermeneutic

reminds the researcher to examine the discursive ever historical, reconfigured, and contingent features of the discourse.

Figure 11: Double Hermeneutic Loop



An IPA double hermeneutic is also said to represent engagement as the researcher makes sense of the participant's sense-making of their own situation. "Probing the surface" and "reading between the lines intuitively" (Tuffour 2017: 4) is inherent in this meaning-making.

4.15.1 Arguments for or Against the Double Hermeneutic Approach

Although the double hermeneutic gives IPA flexibility and versatility (Aisbett 2006: 53), this opens it up to critics who maintain conversely that IPA is riddled with ambiguities and lacking standardisation (Giorgi 2010). Kim (2004) concludes, however, that changes in language form the basis of explanation and exploration, a truly scientific endeavour. A multi-faceted examination expressed hermeneutically through different voices, seen through different lenses, is the spirit of meaning-making. More contemporary models seem to support this theory, going beyond the agent's self-understanding of the phenomenon. According to Smith, Flowers, and Larkin (2009: 28), in many ways, the sum of phenomenological parts is "greater than the whole". The leading argument in favour of using this cyclical method for IPA researchers is to obtain different perspectives on the part-whole coherence of the text. It brings a freshness to each encounter. Throwing new light on introspective phenomenon, such as decision-making in dilemmas, make IPA particularly appealing in this study. Whilst some warn against using this as licence to view researcher accounts are more 'true' than those of

participants (Smith et al. 2009; Kim 2004; Giorgi 2010), but in the CO puzzle, the model does explain how the larger picture is made up of smaller jigsaw pieces.

4.16 The Use of Pen Portrait 'Thumbnail' Summaries

Another way of getting to grips with the vast amounts of data, was to apply the strategy of 'single pen portraits analysis' (SPPA). The technique of summing up data is described in the literature by Blundell and Oakley (2024). Like in both authors' works, SPPA had not formed part of the original research design. It began being practised in Gil-Rodriguez (2022) workshops, where they are known as 'thumbnail summaries'. Hence, in this study, they will be known as 'Case Level Pen Portrait 'Thumbnail' Summaries' (see Appendix 12) to reflect the metamorphosis, hopefully to elicit the best of both proponents' methods. Throughout the process and design of the 'gallery' (see Appendix 12), the research questions were recurrently and consistently reviewed.

Case Level Pen Portrait 'Thumbnail' Summaries are brief resumes, in a condensed version, reflecting the genre of each participants responses at case-level. Applying them also proved a useful tool to ensure manageability at cross-level and as an aide-memoire to keep on track as the analysis became more deeply convoluted. As the first tentative steps towards developing themes and incorporating patterns, the conceptual idea is for summaries to represent the spirit of the data, rather than in ad verbatim account, what Hollway and Jefferson (2013) term "temporal dimensions". This is the particular contribution of Blundell and Oakley's (2024: 56) work. They offer three questions for qualitative researchers to ask themselves to determine whether SPPA is the right type of analysis for them to employ: 1. The missing answer – Have you been able to answer the research question/s? 2. The missing person - Have you lost the person in the data analysis presented? 3. Framing the person – Do you need to put the person back at the centre of their story, to answer your research question?

In addressing these points, in this study, summaries were constructed when first familiarising oneself with data and again reviewed on completion of data collection, like an overview. As a first point of analysis, mostly from field notes, doing so case by case helped to capture each participant's quintessence encapsulating their core sense and meaning making, before moving onto concurrent data. There are lots of advantages of doing this, but there are nonetheless risks incurred, such as interpretation bias, miscuing the argument, misrepresenting the participant, and missing the point of rigour. The aim was to keep true to the life-force of the data (being after all, representative of the participants' lived experience) but warnings in the literature of fragmentation and moving

one step away from the raw data mean their use was cautious. Terminology lacks clarity and there is confusion about the extent to which pen portraits offer descriptive, narrative, or analytical detail. Blundell and Oakley (2024: 44) state the problem is an absence of detailed protocol,

“The scarcity of methodological detail in these articles makes it difficult to engage with pen portraits as a trustworthy form of qualitative analysis.”

In this study, SPPA was addressed by drawing on key buzzwords, elicited from commentary, more or less by skimming each paragraph at the end of each semi-structured interview. The purpose of this phenomenological process was to ‘go back to the thing in itself’. The secondary qualitative dataset was then revisited, elaborated on and the process was repeated – a double Hermeneutic in practice – on data collection completion, ensuring summaries stayed true to their idiographic roots and were thereby trustworthy. What was truly electrifying was “something which made the person come alive for a reader” (Hollway and Jefferson 2013: 70). Pen portraits thus became a wholly more rounded representation of the participants lived experience of conscientious objection, as characteristic of Anna, Betsy, Catherine and so on, as their own thumbnail might be, as unique as their fingerprint. It is holistic and illustrative in so far as it is interpreted and contains demographic detail – what epitomises who the given person is and what they say on the given subject. In this regard the case level pen portrait thumbnail summaries effectually were a prelude to the spectrum of CO views, born of features drawn out of data (see Appendix 10). In phenomenological terms, the *eurbelen* (Eureka! moments) crystallised when these buzzwords extended into Personal Experiential Themes, the scaffolding of the entire thesis. As analysis advanced to cross rather than case level, Group Experiential Themes (GETs) emerged, which the pen portrait thumbnails helped pinpoint.

4.17 IPA and Data Saturation

Since its introduction in grounded theory by Glaser and Strauss (1967), the term ‘data saturation’ has been redefined many times (Saunders et al. 2018). In relation to adequacy of data, it can be taken to mean how much is enough to sufficiently address research questions in both data collection and analysis. What Sandelowski (2008: 875) describes as “informational redundancy”, overload is the point at which no new codes are created, themes are revealed, new ideas surrounding interpretation emerge or any existential and eidetic ideas develop.

In IPA, the major philosophy is one that no data saturation exists (Smith 1999) because of the cyclical, idiographic and iterative nature of analysis. Circumstances change in the temporality of our existence in the lifeworld. New insights are gleaned from different sources, or lenses, ad infinitum. This is inferred as a consciousness, a Hermeneutic momentary snapshot in being and time, a contextualised phenomenon that is largely interpreted by the researcher uniquely to when and where (as well as how) the IPA was conducted.

With reference to this study's phenomenon, for example, CO decision-making means different things to different people, so the possibilities for interpretation of moral reasoning are infinite. The being that appears is a momentary glimpse of truth.

4.18 The Rationale for Using NVivo

The revolutionary proliferation and widespread use of research software to facilitate qualitative data analysis (Zamawe 2015) does not detract from focus on its limitations and drawbacks (Dollah et al. 2017). The accuracy and speed of dealing with large datasets to collect and archive is balanced against expense in considering viable alternatives to pen and paper or Word document. This efficiency and effectiveness is reduced and less relevant in small datasets, where the focus is on why? not, how often? making software unsuitable for every project (Dollah et al. 2017).

Although NVivo can code, store, and report on managed data (including for audit in a collaborative way), it is sometimes criticised for its mathematical leanings towards quantitative empiricism. This aside, it was selected as a method of data management rather than analysis in the early stages only given what a mammoth task this was proving to be. Whilst flexible and sophisticated, NVivo's operations are non-methodological-specific, however. The main advantage of NVivo as a data management tool to conduct this analysis is judged to be the ease of creating and identifying patterns, which admittedly still require interpretation, which is where IPA comes in. King (2004: 263) calls this 'indexing segments', which can be illustratively visualised. It is recognised that ultimate sense-making and meaning-making lies in the remit of the researcher, in the hope that no confusion will arise between thematic analysis and IPA – a potential risk.

Johnston (2006) draws attention to researchers' concerns about losing closeness with the data in the mechanisms of using software packages. This highlights the main NVivo dichotomy – that it is a tool for data collection, organisation, and retrieval rather than analysis, in which the 'doing' is in the mastery of interpretation. A lack of responsive connection with the data and the risks of poor engagement were thus addressed by a hybrid adaptation of techniques including researcher transcription, revisiting the original recordings, and periodically using traditional methods of handwritten analysis.

8. Reflexive Pit Stop – Methodology and Method

Ideally semi-structured interviews are rapport-building, but personal preferences born of being an insider could well have led to challenging researcher: participant relations. As a colleague of some of the participants, a lot had been achieved in orientating participants to the purpose of the study, so this 'unworkability' did not materialise, there appeared a genuine interest and concern about the issues raised sufficient to motivate midwives to partake. The potential effects of a relationship breakdown did occur to me since the topic is polarising. Not only was I more experienced and older, but there was potentially a power imbalance – it took a while to convince the participants I did not consider myself an expert and to reassure them there were no right and wrong answers. Mostly the sharing of insight on decision-making, and lived experience was enjoyable, participants commented. As an insider to the team in some circumstances, I was pleased about this affiliation and proud of the compassion demonstrated by colleagues, sharing professional values, including those participants I did not know. Not all midwives had a pre-existing assumption about the CO concept, some had never realised that was what it was called, but all had clear views on abortion (whether for or against). Particularly in respect of rights to bodily autonomy, undertones of feminist thinking surfaced repeatedly, and the semi-structured interview method allowed both these epistemologies to be explored in a free-flowing, conversational way. Insights generated included a whole plethora of practical, clinical, legislative as well as philosophical questions posed by midwives about midwifery. In addressing these, we hoped to foster greater recognition and more streamlined accommodation of conscientious objection views as well as a more harmonious balance of rights between service-user and provider.

IPA details what the lived experience is like for *this particular* person and what sense *this particular person* makes of it (Smith et al. 2022: 3). It is maintained that reality can only be understood via the human mind and is socially constructed. Since the

researcher may still contribute in part to this, therefore, phenomenological reflexivity is integral to the research design as a consideration of quality, now examined.

Chapter 5 - Quality

5.1 Ensuring Quality

It is generally accepted in research circles that broader aspects of ensuring quality in qualitative research per se relate to assessing validity. Considering quality ensures the status of the research and offers more of a guarantee that any claims made in the research are legitimate.

A well-developed plan for data management at the start of a research project is a way to ensure a solid quality structure for research data from the offset. It gives a reviewable framework to the project and is a way to prevent the need for unnecessary work in hindsight.

The extent of methods' appropriateness and usefulness in measuring what they are designed to measure is pivotal to this quality. Smith et al. (2022) talk also of the research's coherence and contribution to the wider literature as being important to quality.

According to Lincoln and Guba (1985), 'trustworthiness and rigour' are highly relevant to universal qualitative research. Trustworthiness (or the true value) and rigour (how systematically academic conventions are applied) reflect the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit & Beck, 2014).

To achieve these standards, guaranteeing data authenticity of the transcript by the participant, peer review and audit (to check credibility) were undertaken in this study. Strictly speaking, member check was not undertaken, although some points were clarified. This is because in IPA interpretation is captured, caught in 'being and time' which may be interpreted differently by another researcher (or conveyed differently by the same participant at a different time).

In fact, the analysis takes on four criteria of quality devised by Yardley (2008), as recommended in Smith et al. (2009). These were addressed in the study in the following ways:

5.1.1 Sensitivity to Context

Relevant grey literature was reviewed both prior to the study and following data collection and analysis. This enabled theoretical components from other investigators on the subject and methodology to keep knowledge current. Awareness of the dynamic socio-cultural setting was maintained, for example, by subscription to ‘They Work for You’ alerts from the UK parliament to keep track of legislative developments. The Medical Activities Bill, development of clinic buffer zones, telemedicine initiatives, and various rallies on Downing Street (for example Heidi Carter’s ‘Love Doesn’t Count Chromosomes’ campaign to end discriminatory abortion law) all raised consciousness around ethical decision-making in relation to CO. On the international scene, reaction to the reversal of Roe versus Wade, repeal of the eighth amendment of Ireland’s constitution were other examples of this. Reviews of the quality press and social media also took place throughout. IPA suits an appreciation of the participant’s perspective, as discussed, and at regular intervals recordings were revisited to keep primary data fresh. Many of the participants mentioned these events in context, so understanding was imperative.

5.1.2 Commitment and Rigour

The in-depth engagement with the topic, recommended by Yardley (2008) was achieved by regular reading (and re-reading) data. Stenfors et al. (2020: 597) call this “shadowed data”. Reflecting on methodological competence and skill in a learning log or with peer-support was also undertaken. Supervision ensured meticulous attention to accurate detail, applied an inductive, iterative process. The depth/breadth of analysis was achieved by recurrent case-level exploratory noting as PETs, then GETs were devised at ever deeper levels of insight.

5.1.3 Transparency and Coherence

The clarity and power of the descriptive argument was addressed by regular discussion at the IPA Regional Group, mindful of adherence to ethical issue, such as maintaining confidentiality. A Penzu ‘reflexive diary’ was updated at key points in the research process to ensure a suitable “fit between theory and method” (Yardley 2008: 219).

5.1.4 Impact and Importance

Understanding became enriched in the PhD journey and relevance was promoted by opportunities to discuss moral decision-making in relation to the topic by attending

conferences amongst policymakers, workshops with key theorists and fellow health workers. I presented at regular intervals within the organisation, sector and out of the field.

5.2 Reflexivity as an Issue of Quality

Lincoln and Guba (1985) also stress the impossibility and in fact, undesirability of detachment, stating,

“Naturalistic inquirers do not seek to attain objectivity, but they must find ways to articulate and manage their subjective experiences” (Lincoln and Guba: 882)

Through the process of becoming aware of our preconceptions we can attempt to filter the phenomenon being explored (Willig, 2013). This allows the researcher “to own one’s perspective“ (Elliot et al. 1999: 215). This notion of ‘reflexivity’ is described by Willig, (2013) as consisting of two types on a theoretical axis: personal reflexivity and epistemological reflexivity. Willig (2013) suggests personal reflexivity requires reflecting on how our own values and life experiences impact on the research process. How the research affects us as a person and as a researcher is also a reflexive matter. Epistemological reflexivity is regarded as reflecting on the assumptions made during the course of the research and the implications for the research findings (Willig 2013).

5.3 Rationale for Reflexivity

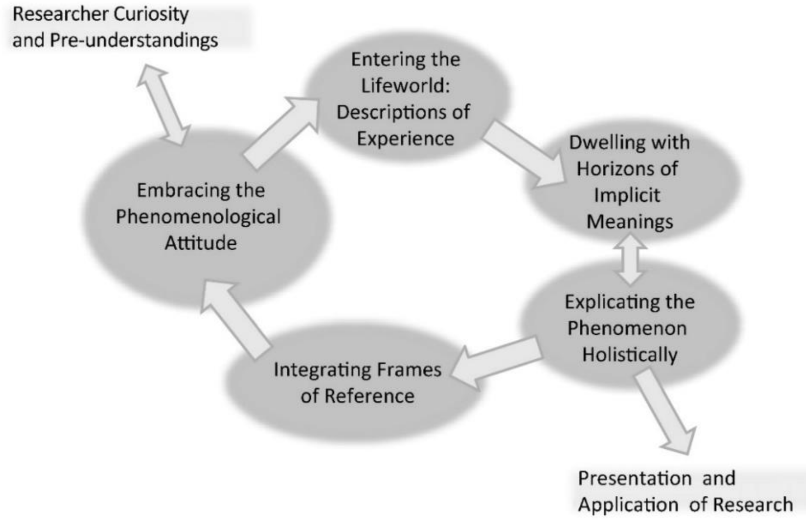
The acceptance of an epistemological stance in this study: that total objectivity is neither obtainable (Frank 1997) nor desirable (Crotty 2003), does not equate to a complete disregard for some element of ‘reflexive bracketing’ (Ahern 1999). Whilst there are differences between the two terms both recognise the potential for researchers to influence data collection and represent a persistent effort to disallow assumptions to shape or impose on the researcher’s understanding. Both also recognise the importance of validity and reliability in research, untainted by the deleterious effects of researcher idiosyncrasies. Despite the shared goal of erasing pre-conceptions and feelings, reflexivity will be the model of choice. This accepts that it is not possible for researchers to put aside influences about which they are not aware which inevitability brings a certain degree of subjectivity. More productive researcher energies towards exploring the effects of an experience, (rather than gauge futile attempts to eliminate them) is deemed the key premise of using a reflexive model.

Stenfors et al. (2020: 598) argue assessing quality needs to be directed towards "depth, richness and appropriateness of the data" rather than the number of respondents. A continual process of engaging with and articulating the place of the researcher within the context of the research, reflexivity was embedded and supported in the research process.

It is perhaps opportune at this juncture to highlight the Smith, Flowers, and Larkin (2009: 189) concept of "bandwidth", which considers how the natural attitude of everyday experience becomes more formal and phenomenological. As a panorama, or spectrum of a range of inquiry, comprising layers of reflection, they suggest progress from an initial glance which is given greater depth by reflexivity, attention or deliberate control, rather like focusing and pondering a complex issue.

As Finlay (1998) points out, if positionality refers to what we know and believe, then reflexivity is about what we do with this knowledge. Essentially, this involves drawing attention to the open-minded and accepted researcher as pretending that they did not have a values-driven impact. Finlay (2013: 172) argues the essence of a phenomenological research approach (which "sees afresh") encompasses five mutually dependent and dynamically iterative processes: (a) embracing the phenomenological attitude, (b) entering the lifeworld (through descriptions of experiences), (c) dwelling with horizons of implicit meanings, (d) explicating the phenomenon holistically, and (e) integrating frames of reference. This is demonstrated in the following illustration.

Figure 12: Iterative Process (Finlay 2013: 175)



Identifying these 'frames of reference' by reflexivity explores dilemmas and challenges so it is well-suited to a study of this genre. Not to say that findings were assured to be

completely objective, but reflexivity narrows the gap between researcher and researched to open less judgmental research (Patnaik 2013) (as far as possible in a social science, (Finlay 2008).

For Morawski (2014: 1653), the matter of reflexivity is between consciousness and unconsciousness, self-awareness, and self-reflection,

"The back-and-forth process whereby an account of reality depends on pre-existing knowledge of that account. This sense of the concept acknowledges that the knower and knowledge generated cannot be fully separated."

This study will draw on the work of Denzin and Lincoln (2018) who hold that how beliefs are enacted provides the theoretical constructs that guide the researcher. In IPA, the elimination of outside factors which disturb perceptions, known as 'phenomenological reduction', is an integral part of research design, though it is debateable whether this is (or ought to be) fully achievable because interpretation is an essential tenet of IPA. This involves exercising judgment. Whilst an unbiased approach is desirable, by very nature, pre-understandings make up that interpretation, without which there is no contention, no dilemma. In IPA, the researcher is an essential part of the way the philosophical and theoretical choices of the research are made. "The art, practice and politics of interpretation" is informed by the researcher as, "a social actor" (Denzin and Lincoln 2018: 12). Given the 'embeddedness', some researchers question if the pre-requisite conditions of a 'pre-supposition less' stance are being truly met. There is a balance, they state, which calls for researchers to distinguish between allowing for more engaged and enquiry-driven, phenomenological qualitative research and championing a more esoteric or subjectivist approach (Emiliussen et al. 2021: 5).

To this end, examination of one's own belief systems, judgements and practices was upheld using a Penzu electronic, reflexive journal. This served the purpose of questioning assumptions about what I know, and how I know it as this may have influenced the research. The aim was to ensure transparency and expand horizons of understanding as far as possible.

5.4 Quality Markers of Nizza, Farr and Smith (2021)

According to Nizza, Farr and Smith (2021), evaluating quality in IPA research has four 'markers'.

Table 5: Four Markers for Evaluating Quality in IPA Research (Nizza, Farr and Smith 2021: 4)

Quality indicator	Brief description
Constructing a compelling, unfolding narrative	The analysis tells a persuasive and coherent story. The narrative is built cumulatively through an unfolding analytic dialogue between carefully selected and interpreted extracts from participants.
Developing a vigorous experiential and/or existential account	Focus on the important experiential and/or existential meaning of participants' accounts gives depth to the analysis.
Close analytic reading of participants' words	Thorough analysis and interpretation of quoted material within the narrative helps give meaning to the data and the experience it describes.
Attending to convergence and divergence	Idiographic depth and systematic comparison between participants create a dynamic interweaving of patterns of similarity and individual idiosyncrasy.

Each of these essential components will be considered in turn:

5.4.1 Constructing a Compelling, Unfolding Narrative

Insofar as IPA examines a topic, as far as possible, in its own terms (Eatough and Smith 2017), the unfolding narrative is predominantly and compellingly that of the participant's, who all commented on the lived experiences of ethical dilemmas in relation to CO decision-making. There exists a focus on participants' meaning-making (Smith, Flowers, and Larkin 2009), which supported a tolerance of CO, but in which their positionality was predominantly supportive of legal abortion, albeit conditional. Although the analysis comprises a beginning, middle and end, following a sequential flow of ideas, it could be said to incorporate another stage in its development - a conceptual beginning. This considers theoretical components as an issue of quality (Yardley 2008) and ensures the study addresses knowledge gaps. The narrative may be guided by the interview schedule, admittedly, yet was free flowing enough to capture each participant perspectives on how their moral development has metamorphosed with working in

women's health. From the outset, from the participant's clarification of terminology, each participant gives their own slant on what the CO concept is defined as. Each narrative adopts highly individualised twists and turns. In the study, these touch base sometimes on wider midwifery, societal and cultural issues with due emphasis on their lived experience of ethical dilemmas and moral decision-making.

Expression of the Hermeneutic circle connecting part and whole is another feature of quality IPA research (Smith 2007). To this end, participants' understanding of what CO comprises, their stance on abortion and their position in the CO debate is the *starting gun* to their sense and meaning making, giving a flavour of the narrative to follow. It is the foundation on which all other discussions rest. Participants often refer back to their experience and it is this facilitated self-reflection that is such an integral part of the dual learning and empathic experience of the research dynamic.

Notwithstanding, the analysis is presented in an interconnected way *within* and *across* themes, which Nizza et al. (2021) highlight as another key quality component. Using the example of Gillian's transcript, she acknowledges that her religious affiliation was a source of dilemma which she later relates to her beliefs around when life begins, *"For me personally, I believe life started from when it started, you know? The eggs have been fertilized. Life has started. That's how I (that's how I) think of it" (Gillian 79-81).* The trajectory leads into the 'Personal Experiential Theme' (PET) 'Practising Midwife, Practising Religion'. In short, her faith does surface throughout in a theological theme, but it is interwoven with a second theme, 'Navigating with a Moral Compass' which converges with data from other participants. The value of human life may well have been a motivation for joining the midwifery profession, but, like others, CO to abortion is a dilemma *"something on which I had to ponder a lot" (Gillian 42-43), "not my own moral compass on other people" (Gillian 53-54).* Carefully selected participant quotes, analytically interpreted, took the narrative further. Part of the way the narrative unfolds is in illumination of the ethical decision-making process, how choice is exercised, and other associated dilemmas expostulated in the analysis.

5.4.2 Developing a Vigorous Experiential and/or Existential Account

Smith (2019: 167) states,

"What turns an event into an experience is the degree of significance bestowed on it by a person, whose sense-making of it imbues it with different levels of experiential or existential meaning."

Deep and meaningful significance is attributed because of participants' lived experience of a phenomenon. For example, Gillian's account of colleagues who've needed support in the workplace and who've actually left the profession affords the issue of dilemmas greater significance.

In considering the researcher's role in making sense and meaning-making to the participants' own sense and meaning-making, the following typology may be useful.

Table 6: A Typology of Meaning (Smith 2019: 168)

Type of question	*Level of Analysis*	*Density of IPA focus*
1. What does *that* mean?	Literal	**I**
2. What does *he* mean?	Pragmatic/textual (puzzle)	**III**
3. What does it *mean*?	Experiential (significance)	**IIIII**
4. What does it *mean* for my identity?	Existential (significance)	**III**
5. What does my life *mean*?	Existential (purpose)	**II**

It shows the depths of analysis, which may be layered like an onion, peeled back by the types of probing questions asked at interview from superficial (for instance, 'Can you tell me about your understanding of the term CO?' 'Have you experienced CO?'), to a gauge of experiential significance (for instance, 'How could the situation be improved do you think?'). Piecing together pieces of a puzzle to solve an enigmatic equation is all part of the problem-solving.

For Elliot et al. (1999), it is with resonance for the reader that the real meaning lies and in terms of quality, it is ultimately for them that there needs to be an accurate portrayal of the phenomenon.

5.4.3 Close Analytic Reading of Participants' Words

According to Nizza et al. (2021: 376),

"Close reading of participant quotes can reveal the deeper significance of the particular relationship between the participant and the experience."

Colourful imagery and metaphor are provided by Gillian, with useful analogies to choice of feeding methods, anti-vaxers and rich descriptions of caring for women in birth. This serves the purpose in the data of highlighting how commonly midwives are faced with

disagreement dilemmas in everyday practice, not all of which are vocalised. It helps home in on norms of behaviours amongst professionals dealing with service-users whose choices may differ and the kind of value judgments often made, dilemmas which may be internalised or decision-making which may not be explicitly communicated.

Overall, focusing on the process of critical engagement, as advocated by Gil-Rodriguez (2022) to become completely immersed in the data, was achieved by self-transcription, review and re-review of the data. Moving back and forth between the meaning in the language chosen and the knowledge underpinning the interpretation implies an active role of the researcher.

5.4.4 Attending to Convergence and Divergence

In research terms, convergence involves the researcher looking for patterning related to the homogeneity of the sampling with varying degrees of shared characteristics and uniformity. This is not identical, but with the purpose of examining forms of variability, or divergence. In the 'Gestalt' dynamics of the relationships between PETs and GETs, independence and/or inter-relatedness, are paramount (Smith et al. 2022: 44). An idiographic, yet iterative process keeps data true to the participants' voice.

In looking at the synchronicity of interpretation (whether results yielded are the same or different), literature reveals four strategies for taking divergence into account: reconciliation, initiation, bracketing and exclusion (Pluye et al. 2009).

In doing so, it is important to remember further additional criteria for a good IPA paper, identified by Nizza et al. (2021), which feature in the study's design, analysis, and write-up:

i) Keeping focused and offering depth
ii) Presenting strong data and interpretation
iii) Engaging and enlightening the reader

Chapter 6 - Findings

6.0.1 Introduction

The Findings chapter of the thesis contains excerpts from data – the pure essence of the participants' voice and my interpretation of that voice. It is structured according to six devised Group Experiential Themes (GETs):

Table 7: Group Experiential Themes

	GROUP EXPERIENTIAL THEME	PERSONAL EXPERIENTIAL THEMES
1	**Practising midwife, practising religion**	Thou shalt not kill
		Reinforcing attitudes to procreation
		Let her without sin cast the first stone
2	**Navigating with a moral compass**	An issue for conscience
		Thought and moral processes
		Mentally traumatised
3	**Fearing reviving, surviving, and thriving**	Encountering a diagnosis minefield
		Living a full, full life
		Medical marvels at 22 weeks
		CO crises at the cusp of life
4	**Being torn between wearing two hats**	Putting beliefs into a box
		Ensuring the patient comes first
		Respecting different views
		Being a midwife in the room – What? When? Who should I tell?
5	**Two signatures and the escape clause**	Is it legal?
		Understanding the conscience clause
		A fresh look at conscience policy
6	**The right midwife, delivering the right care**	Achieving a Harmonious Balance
		Changing job descriptions
		Managing CO since 1967

These were created from two or more Personal Experiential Themes (PETs), themselves the product of common concepts represented in the exploratory notes, often directly from dialogue. GETs are hereby briefly explained:

1. Practising Midwife, Practising Religion

Refers to the theological, religion-based, and ideological origins of CO.

2. Navigating with a Moral Compass
   Wider conscience-based considerations. An examination of moral reasoning and mechanisms for ethical decision-making.
3. Fearing Reviving, Surviving and Thriving
   Fetal and neonatology-focussed dilemmas around resuscitation and CO crises at the cusp of life.
4. Being Torn Between Wearing Two Hats
   The sexual and reproductive health questions arising from dealing with two lives or alternatively a combination of roles. A metaphor for the ubiquitous nature of professional versus personal dilemmas.
5. Two Signatures and the Escape Clause
   The 1967 Abortion Act stipulates the requirement of two medically registered practitioners' signatures. This theme addresses medico-legal aspects of policy in relation to section 4 (1): the conscience clause.
6. The Right Midwife Delivering the Right Care
   Facilitating needs of the service and the patient's choice through accommodation; a close inspection of solutions put forward by participants to invoke a harmonious balance of midwives' freedom of conscience with the components of appropriate care.

The insight into lived experience of CO will touch upon societal foundations and influences. As participants reflect, they pinpoint their pre-understandings, give sense and make meaning both from their own and others' lived experience and hypothetical scenarios. The premise will be adopted that definitions of CO relate closely to conceptualisation of what is 'participation'. This will help identify what controversies surround procedures and what participants devise to resolve any issues as they perceive it. Outlining how abortion is operationalised will bridge the gap between belief and behaviour, inextricably bound with dilemmas and delivery of care.

Exploring how participants balance the arguments leads later in the discussion to the development of a 'Model of CO Definition' and 'Framework of Moral Reasoning'. These examine on what basis do midwives define, conceptualise and accredit conscientious objection and on what judgments do they act. This demonstrates that decision-making is much more than legal, professional, and clinical but philosophical, morally reasoned and ethically principled.

Interpreting the Abortion Act and its reiteration in policy therefore follows next. Opinions on legalities and how well policy provides for the midwives' role features in this section. Lived experience of conscientious objection varies – the highly individualised dynamics of how freedom of conscience manifests in practice are highlighted as they affect midwives themselves or the teams and organisations in which they practise, theme by theme. As agents of the state or advocates of the service-user, we look at how midwives balance and reflect on their own moral judgments to decide on what constitutes eithical or 'right' action. We reflect on the internal mechanisms employed in employment, firstly, as practising midwives, practising religion.

6.1 Theme 1 – Practising Midwife, Practising Religion

Although this theme recognises 'the church' (or institutions of worship) as a social construct, conscientious objection is not exclusively confined to Roman Catholicism or indeed, Christian observance. Conscientious objection is considered a matter of spirituality: pre-understandings born only partially of religious beliefs about conception, when life begins, the concept of human dignity and the sanctity of life are reflected. There are, however, terms considered to be from the RC lexicon itself, which I include here for the benefit of all readers (see Appendix 15).

This first GET reflects the predominant influence of theology with regard to conscience rationale and the religious undertones in each participants' data. It covers the types of challenges practitioners face when they balance positions of standing within the professional community with a religious authority guiding the believer. For example, like other observant participants who confess their faith, Anna draws on theological motivation in her moral reasoning around abortion and the challenges posed by CO,

"Possibly religious reasons, because it's against the Catholic religion to abort. Very strong pro-life opinions…I suppose…the midwife has to feel comfortable with what she is doing, as long as there is someone to watch the women." (Anna 85-89)

Many of the participants use scriptural authority to justify their point of view as if in doing so, comments carry more weight and credibility. Scriptural references are also used with humour*, "I guess that's the religious thing. You know, whether it's divine, I suppose. Hmmm – 'When does life start? Discuss.' (Peter 109-110).*

Maria relates health tourism to the unacceptability of abortion in certain communities and attributes this in part to the power of the institution,

“Sort of, you had people over (and we still get(s) people) coming over from Ireland because it was wrong for the Catholic church – just in terms of the power the church had then to what it has now, it has lost lots of power. Respect amongst younger people, too: we had to respect our Priest… The whole sort of sex before marriage and the sanctity of being married was absolutely massive, whereas it’s not so much so now. Whether that’s a good or a bad thing (shrugs and questions)? (238-247)

Jane reflects on historical origins and on religious teaching as a mechanism for ethical decision-making,

“I can see how religious factors would come into it, but I am not convinced that in England, we’ve got strong Catholics anymore. I mean, I am Catholic myself and I would describe myself as pro-choice, but not to the point of idealism…. I don’t think (religion) is as strong when you look back in our history. No, I think people are more informed, in general. I think people are more educated than what they were in our history. Erm, people may still have their beliefs, but you know? I suppose in my grandmother’s time, it would be ‘you did what the priest said’. Or you did what the doctor said. Sadly, there was some good that came out of religion: and there was some bad.“ (Jane 210-221)

In thinking of a religious component of conscientious objection, participants place onus on rules-based ethics but fall short of handing over authority to an omnipotent and omniscient higher power, since she questions priests’ authority,

“I’ve been in church on many occasions, when the Priest has damned and, you know? I’ve wanted to put m’hand up and say, ‘Wait a minute!’. I just feel that those individual women have the ultimate right to choose.” (Jane 118-120).

Likewise, Hannah faces dilemmas related to being a practising midwife, practising religion when her personal views, faith and professional obligations are incongruent,

“They're not allowed to take part in abortions - as being a Muslim, but then I have my own views as well because it is up to the women, really, if they want, that's what they've opted to do. They've decided - it's a big decision for them. It's not just opted to do it, and in the hospital especially, but in the abortion clinic I can see where they're coming from, but it's hard. It's a big, hard decision.” (Hannah 37-41)

6.1.1 Thou Shalt Not Kill

'Thou Shalt Not Kill' is a direct biblical quote incorporated in data by Ivy (151) and the sentiment that life is sacred is a common feature. Almost like a priest may give a blessing, Catherine's CO experience is described as "*a touch-point exercise".* She reflects on freedom of conscience management. Catherine notes an objector's religious observance in an affectionate way, saying it is: "*very dear to her and actually dear to all of us"* (*55)…*

"She didn't feel because of her religious beliefs that she could care for somebody who had been associated with ending of a pregnancy…Although she was a very experienced surgical nurse, she didn't want to participate in that and had a lot of difficulty with it and it wasn't about the morals or the suggested morals of the women, it was about the ending of a life. By the individual, not that it had any bearing on the woman's background or how she was presenting. It was totally.... the act she was being asked to perform that she was in disagreement with was ending a life." (Catherine 62-67)

Although the nurse objects, Catherine is keen to stress the other's decision-making – she does not judge "*the morals or suggested morals of the women" (64)* but abides more with a religious doctrine above professional dictate: the requirements of her faith above the expectations of being a midwife. Catherine's observations railroad the kind of casting aspersions on others sometimes made in social attitudes towards abortion and about highly politicised objectors,

"People think objection is about standing there with your banner saying 'No, no, no!'." (Ivy 273-274)

Allegations of lacking Humanitarianism abound on both sides of the debate. Conscientious objection does present as a dilemma more predominantly for several participants, who do or did attend institutions of worship, which seems to suggest some association. Conscientious objection remains a transient concept in that views of dilemmas may change over time. Talking about her own mellowed and compromised beliefs,

"I think they've merged into one over the years. Probably when I was younger, I was, like, 'Oh, know that it's so wrong'. But over the years, I do believe that they've merged into one. Obviously, I do believe everyone has the right and choice. It may be the wrong decision for me, and hopefully it's one that I will never have to make. (Maria lines 26-30)

Maria's "*belief that life is sacred. I still believe that life is sacred" (line 239)* shows how her religious upbringing remains a key component of her midwifery rationale. Maria acknowledges the gravitas in what others go through and this dilemma of perspective was influenced by her early religious upbringing. In her tolerant approach, she presents herself as a compassionate professional; a midwife who recognises she is without liberty to 'judge'. "*But, you know, we are all victims of circumstance, really, aren't we?" (Maria line 30)*

The Muslim perspective on pregnancy is very much bound with god's will, and the preciousness of that 'given' life,

"(Abortion) is not allowed at all. That God's given you this life that you should be providing for. So, I mean, you just carry on with it. You see some women (I've seen a case) where a woman had like, I think she had like five or six daughters, and she was given this." (Hannah 354-356)

Reliance on a just deity to explain the course of events is very much a philosophy featured in Hannah's data,

"She'll say, 'That it's how it was written, that is how God had actually written it for her: that this baby wasn't going to live'" (Hannah 382-383)

She gives a very moving account of a selfless family she cared for whose decision not to abort for a congenital condition, was founded in complete confidence in god rather than take the advice of professionals, diagnosing anencephaly,

"I remember this lady. I'm sure she had a section because she didn't want to put any pressure on baby's head, and I remember thinking that this baby is not compatible with life. So why are you going through all this? In their head, they was just thinking that 'It's gonna be fine. It'll be fine…it did pass away, after a few hours, but in their mind, they just kept thinking. 'No, it'll be. All will be OK' …(now) she'll say, 'That it's how it was written, that is how God had actually written it for her: that this baby wasn't going to live'. If she had had the baby aborted, she might have actually thought, "No, it might have been alright.'" (Hannah 373-386)

6.1.2 Reinforcing Attitudes to Procreation

Betsy's expression of her own faith personifies her lived experience and shows where her CO pre-understandings originated. Attributes, *'ingrained'* attitudes (like care and

compassion) are as much a part of '*behaviours that you display throughout your life".* Boundaries between "*inner self*" (a reference to conscience, or the inner voice) and workplace boundaries may be blurred,

"If I start with religious then, because that is a personal thing to me….the same with education, I believe that you can liken that to a religion as well. You know you're educated really by your family, by the church that you've decided to become a part of and that is ingrained…in your…inner self, really and all of the behaviours that you display throughout your life….we are raised that way then it's cultural and it's within you. It's your beliefs. It's very difficult to sometimes to differentiate. That there are midwives I know that won't work on a Sunday, you know, and they don't because that's the Sabbath day. You know the church will say that, uh, maybe we shouldn't work on a Sunday. It's a Family Day. It's a day for going to church." (Betsy 90-98)

Sex education in religious settings reinforces teaching on attitudes to procreation, contraception, and abortion. Co-ordinated by the Mother's Union reminiscences of class-taught sex education with a bearing on tolerance and rights being taught in Sunday school features nostalgically in Catherine's data. She forwards that modern midwives may have greater orientation to conscientious objection due to this rights' awareness but there remain resounding theological underpinnings.

Comments show that beliefs positioning life being sacred are part of midwives' raison d'etre to this day. With an element of self-questioning, Maria reflects on the changing status of women and loss of reverent attitudes to those in traditionally religious authority,

"There was a lot more emphasis on the church…There was a lot of input in families from the church and the belief that life is sacred. I still believe that life is sacred. But in terms of anti-abortion, it was quite pivotal, wasn't it? Sort of, you had people…coming over from Ireland because it was wrong for the Catholic church – just in terms of the power the church had then to what it has now, it has lost lots of power…. I would say in terms of society, I would definitely say the religious input has sort of come out. And in terms of women, women are definitely different characters to what we were then. The whole sort of sex before marriage and the sanctity of being married was absolutely massive, whereas it's not so much so now." (Maria 237-251)

Maria observes changing societal attitudes, with less emphasis on instructive, rules-based reasoning, but ultimately, she seems to approve of the freedom of choice this has brought,

“Whether that’s a good or a bad thing (shrugs)…contraception: all those types of things. Yes definitely, society has got a massive input into why we feel as we feel now. And I think that’s probably why my thought processes changed a lot over the years.... because obviously you see, don’t we? So many things are acceptable. That freedom of choice is so pivotal now, whereas it was: that was what the church says, these are the rules, you live by them.” (Maria 251-255)

Diane’s insight also gives an indication of attitudes surrounding sexuality being developed at a young age. When Diane talks of her developing morality and how this ultimately evolved into CO, it is as a tentative recollection first,

“As a Catholic, the way that we were taught in terms of sex education was that termination on any (stammers) grounds was wrong and (stammers) we actually saw (it) as part of our sexual health education programmes. We watched the video from the Society for the Protection of the Unborn Child and at that stage…none of our parents were asked for consent for that, but I mean we're talking 30 years ago. But I remember doing that as part of my GCSE projects about abortion and … abortion at that time as a girl at 15-16 was wrong. Then you move up you mature, and you realize that, unfortunately, life doesn't give everybody the opportunities. In life, it is not as black and white as you think.” (Diane 98-105)

It is interesting that Diane notes the power of SPUC which overrides parental rights. In her long-lasting shock at the video’s content and in imparting its impact, Diane is making sense and meaning of the church’s influence on the community’s behaviour. Whether condoning, or punishing, approving, or disapproving the institution’s reach into the home still resounds with Dianne to this day.

6.1.3 Let Her Without Sin Cast the First Stone

All participants take a very pragmatic approach to providing non-judgmental care, almost as if a gold standard. Maria’s decision-making is a humane one of compassion, charity and understanding,

“There’s a lot of room for us to judge and in any situation, lots of room to make a judgement that’s not your judgement to make. A bit like, if you are religious, ‘Let those without sin, cast the first stone!’ …I would just try and focus on the woman and make this as easy as you can for her, make her comfortable, make her pain-free, etcetera, that sort of thing.” (Maria lines 324-327)

Another rich religious illustration of this charity comes from Ivy, a pearl in the data,

"I once worked with a doctor, he used to always say, 'I always worry that when I get to the pearly gates, I don't know if God will kick me out' (because of the things he had been involved in and the things he had done). And somebody said, (and I do believe this) that, 'my God wouldn't judge you for supporting somebody'. You know, so I sort of think, that yes, it's something I don't want to be openly involved in, not openly.... I am thinking that God, your morals (whatever it is), looks at a bigger picture." (Ivy 77-83)

Passing judgment, having moral agency, and displaying complicity for the taking of life, is likened by Peter to *"Playing God"* but it is an omnipotence treated with caution and in trepidation,

"I am not saying I passed a judgement, I am saying I wasn't expecting to go through all of this thought and moral processes at 7 o'clock on a Wednesday night when I've turned up to work. I thought I knew where I sat on this. Now I'm going to be the one who's playing God! I don't mean pulling the trigger, but it's you who is actually pressing the button, if you like. If you didn't do it, the whole process couldn't start." (Peter 227-231)

For Peter, who tries to do his job in a non-judgmental way by being "*professional and supportive." (122),* casting aspersion on the rights and wrongs of the abortion decision fits poorly with professionalism,

"*As difficult as I find it (because I don't find it easy), it's not for me to make those decisions - that I will support people as best I can. I don't know what has brought people to those decisions where it's almost not my business." (Peter 120-122)*

Although forgiveness is very much a theme running through the data, Gillian commits to a more rights-based approach where professional responsibilities take precedence: a practising midwife first rather than one primarily practising religion,

"You have to think of the rights of that person you are treating and not yours 'cause if you're put into a position for that, you might go say ten 'Hail Maria' at the end of the day." (Gillian 440-441)

6.2 Theme 2 - Navigating with a Moral Compass

'Navigating with a Moral Compass' is a metaphorical phrase representing signposting along the winding pathway of ethical reasoning. It implies being directionless on the

abortion journey, lost or facing a crossroads and having to decide which way to turn, and to whom. From a care providers' point of view, for Peter, decision-making begins with career pathway choices,

"Equally I can see that midwifery is interdisciplinary, in that sense. You can't just go well, in midwifery, 'I just want to be a homebirth midwife, I just want to be a high-dependency midwife. I want to just deal with that side. I don't want to deal with that side. You can't, you just can't separate out those strands. You can't pick and choose the bits that suit you." (Peter 164-167)

Making moral decisions with impartiality is central to the safety of caregiving in CO, suggests Gillian,

"Look on the other side … remember that you know, no creed, race or that sort of thing where we have to deliver…health care regardless of where that person is, you know in terms of, uh, the protected specifications and things like that. Not my own moral compass on other people." (Gillian 51-54)

6.2.1 An Issue of Conscience

All participants know about the theological origins of freedom of conscience, but some are adamant in explaining their conviction that objection can also be conscience-based, in accordance with moral beliefs or on principle, almost as if to distance themselves from the illogical or unreasonable to present themselves in a more considered way. Practising midwives, practising religion are no more morally right by the nature of their faith, it is deemed. Believing in fetal rights to life does not depend on religious practice or being a midwife, participants like Peter assert.

"It's really important that just because you don't have a strong religious conviction does not mean that are not affected by the complexities of these moral/ethical dilemmas and I worry that this can get lost in the debate. So sorry not to be able to give a yes/no answer!"

Conscientious objection both closely supports and is itself supported by law, so the law and medico-legal dilemmas of conscience sometimes overlap,

"I still do believe as well, strongly, that everyone have a right to their own rights…A person also have a right for things not to turn out right. If that is their decision. Because we are in the health care profession, you sort of want to fix everything and make sure

everything is OK: But people do have a right not to want things to be OK. You do have Jehovah's Witness for which its possible- you also have, like, anti-vaxers and … lots of things that people object to that (which) could actually save your life, but then will it? Doesn't necessarily mean it will. That's just what we've been taught. But it doesn't necessarily mean that might save their life, but that's just ingrained in my thought process…Yes, I do believe people have the right to conscientiously object. I might not like it, but I do believe they've a right yeah?" (Gillian 135-146)

Gillian's premise is that there are limits of practitioners' autonomy if expression of freedom of conscience negatively affects others,

"I could walk away. Don't I feel all happy with myself that I objected but ....erm, what have I done to that woman? You know, it really is a moral dilemma to work through because I know, like I said before, I could put my beliefs in a little box, until the end of my shift, because I sorta go into that medical mode where in the back of my mind is what I believe. But I'm here, I'm not here for me though. This is not about me, I'm not there for me. You know I'm there to help this woman in her choices." (Gillian 440-447)

Francesca (20-21) supports this,

"It's just another avenue of maternity care for me, you know, and these women, you know, there are times in their life when it it's not right to have a baby and there's got to be a midwife there that understands that, come and still provide them with the care that they need, without judgement."

Balancing the weight of dilemmas, on ethical scales, participants are keen to stress that conscientious objection is much more than a religious consideration. It is an issue for conscience. Having acknowledged the religious authority and spiritual dimensions influencing decision-making, we will now look at the intellectual, psychological, and cognitive processes that practitioners go through in resolving their dilemmas.

6.2.2 Thought and Moral Processes

Anna's is very much a reflection on the nature of woman-centredness, which recognises her own moderate stand as a pre-condition of helping others,

"I wouldn't put my personal views onto others, depending on what the woman needed at the time, I don't think I would have any particularly strong beliefs, either way. I just want to support her in going through what she's going through because it's hard enough,

really, to do what she's doing, I think, without coming across people who are (hesitates) conscientiously objecting." (Anna 61-65)

The defence of patients rights, of choice, advocated in Anna's first statement here, do not detract from the insight we gain into her ethical dilemmas in maintaining this pro-abortion stance,

"*I just feel it's up to the woman, and that's her decision. I can understand why people might object, you know, you can see that the woman's having frequent terminations for non-medical reasons, I suppose. That doesn't sit comfortably with me. But again, it's still up to her, whatever she wants to do with her own body. If she feels she doesn't want to have a baby, that's her choice." (Anna 121-125)*

Most participants similarly stress their support for abortion rests conditionally – it is an endorsement only to varying degrees. Although an abortion defender, Jane seems to imply infringing choice is outside the remit of the professional,

"Nobody has put me, I have never been put in that position to have to say, 'No, wait a minute - I don't want to'. From a managerial perspective, with staff, I've had that. But for myself, I've never been in a position. I would consider myself …professional (a) bit would override any personal thoughts. My own thoughts are that women should have a choice." (Jane 42-47)

Like Jane, here, Peter suggests other more subjective and existential influences may be afoot in the hands-on practice of midwifery, with a bearing on conscience,

"It's that visceral thing of being the person, in the room, who kind of eyeballs the person and says, 'I am going to be the person who would start the ball rolling until your baby is born.'. And I am giving all the emotional support whilst trying to internalise all of those kinds of dilemmas, in a time when I haven't had any time to process this. I've got just get on with it. I can't think about it. I think that's really hard. Can't speak for other professions but I think it's a uniquely challenging way for midwives in a way that it isn't for other professionals. I think it's different on gynae – and I am making that distinction because midwives aren't involved there. Mostly." (Peter 381-387)

Differing definitions of viable, human life make the issues of conscience more complex with an element of moral complicity to the participation in abortion,

"This is interesting because I thought I knew where I stood on this, but now I'm going to go in and I'm going to administer this drug which is going to kill him (I wouldn't say kill because, well kill is such a loaded, emotive word) so let's say, bring about an end to this life, though it's not my decision, but I am part of this process – so I've got to feel comfortable with that. You're asked to make this decision almost like that!" (Peter 197-215)

These internalised and intuitive judgments are characterised by self-analysing and self-bargaining. Peter's perspective on moral agency (ending life) is that it is *"unique to midwives in a way that it isn't for other professionals" (386*). A large part of this ethical and emotional angst is the same for Hannah,

"Why wouldn't they participate in the feticide? Because feticide, we think of it as killing the baby straight away, and I think it's hard for us to actually do that as a … as a midwife (or any profession) … I think it would stay on your mind. It has to be a different kind of person to actually provide that and do that…. I think we take information and take it home with us. A case like an abortion or a fetal death stays with us for a while, so doing something like a feticide, how it would affect us?" (Hannah 183-187)

It is interesting how maverick Hannah's views are in this regard which we get a sense of through her atypical attitudes to contraception. Her overseas placement story reinforces her message on the importance of a caring, Egalitarian service, free at the point of delivery. A strong advocate of the NHS, she discusses the potentially dire consequences of not providing a legally endorsed, safe and accessible abortion service– very much part of the constitutional values of the NHS. Having been the only participant with family experience of abortion-related maternal mortality, she has insight into the tragic realities in a way that the other participants do not. The loss of her relative drives home and impacts on the listener, the mental traumas experienced when pregnancy outcomes are not always positive.

6.2.3 Mentally Traumatised

In stark symbolic interactionism, midwives being affected negatively by their professional role continues to the theme, 'Mentally traumatised', dilemmas inspired by Betsy's words,

"A woman comes in and she comes in in spontaneous labour what? 20 weeks let's say that gestation for now? And it's born with signs of life. And you know, I've, we've sat there and watched and watched they all she can do is give it to give the baby to her,

erm, to hold while it passes away. I've also been involved in in cases where the baby's been about 25/26 weeks and got lots of chromosomal abnormalities, The paediatricians and the obstetricians have advised to terminate. She's declined to do that. She's gone into labour, and, you know, and you sit there and watch … watch the watched they all she can do is give it to give the baby to her, erm, to hold while it passes away. I've also been involved in in cases where the baby's been about 25/26 weeks and got lots of chromosomal abnormalities, The paediatricians and the obstetricians have advised to terminate. She's declined to do that. She's gone into labour, and, you know, and you sit there and watch … watch the baby die in front of them, yeah, they're quite ethical, and now I've watched some be very traumatised over those cases. Like mentally traumatised." (Betsy 405-412)

There are ample examples in the data of the real application of conscientious objection, as a philosophical, psychological, and theological concept beneath which personal boundaries spill into everyday midwifery practice,

"Maybe your own personal experience of...having made a personal choice and having to decide which side you came down on, might affect your experience as well. Because, the thing is, if you think about it, it's one thing to think about it in a kind of theoretical realm and another to experience it viscerally – that may lead to a degree of trauma which you think, 'I thought I was ok with it but now, I am not." (Peter 100-105)

There is an element of regret in Hannah's remarks, in which she also copes with mental trauma by recognising the limits of her scope of practice and putting to one side any emotional responses,

"*Sometimes you deliver these babies, and they look a perfect thing you think, 'Oh my God, what have you done?' But it is like you say, it's not up to us. It is that they've actually thought about this decision, long and hard, and how it's going to affect their lives. No, it's not up to us to think of that." (Hannah 45-49)*

Likewise, Hannah faces dilemmas made more arduous by doctrine, which she morally reasons by placing onus on the service-user,

"They're not allowed to take part in abortions - as being a Muslim, but then I have my own views as well because it is up to the women, really, if they want, that's what they've opted to do. They've decided - it's a big decision for them. It's not just opted to do it, and

in the hospital especially, but in the abortion clinic I can see where they're coming from, but it's hard. It's a big, hard decision." (Hannah 37-41)

In echoing ideas of the trauma of the situation, compartmentalising any difficult feelings, here Hannah arrives full circle in issues for conscience. Consider the following passage from Jane, who uses Consequential ethics in emphasising abortion "*with an element of responsibility" (125)*.

"Understanding because it is about a life. But, two – there are repercussions and consequences of every decision." (Jane 129-131)

6.3 Theme 3 - Fearing Reviving, Surviving and Thriving

Midwives' endeavouring to achieve the best outcome for the pregnancy at the same time as trying to predict outcomes for the newborn feature in this third GET, a phenomenon impressed first by Anna,

"The age of viability is a big question, really, isn't it? As medical science advances, there are going to be younger and younger babies able to be looked after, born and survive, and, hopefully, thrive." (Anna 135-137)

Midwives may well ponder 'What to do if the baby shows signs of life? Will the baby be healthy and what is the likelihood of survival?' Often linked to gestational viability, these CO crises may relate to urgent interventions accompanied by dilemmas 'If not by me, then, by whom? If not now, then when?' particularly around the 24-week age of viability or when arguments surrounding potentiality pose another CO crisis,

"Maybe if that baby had anencephaly or a different Trisomy, whatever, then I suspect it wouldn't have triggered so many conflicting emotions in me. But I was, like hhh-mm." (Peter 195-197)

6.3.1 Encountering a Diagnosis Minefield

The first PET therefore reinforces the idea that fetal chromosomal conditions bear weight on moral reasoning. Entitled *"a minefield"* by Ivy (317), because of the clinical and ethical nuances of dealing with different disabilities, thoughts turn to a quest for perfection,

"It's also like creating the perfect baby, so to speak. Maybe my views will also change more in years to come because being involved in research, we were very much involved in the Rapid study (which looked at Harmonie which looks to detect fetal cells from the blood cells and that is a minefield in the things they can detect. Potentially that can detect if your child is likely to have dyslexia in the future. Now that to me that is not a reason to abort your baby – it's natural selection. You know what I mean? There's a difference between having a healthy baby with a good quality of life … and selection. You know, to that point at which you say, 'Well, I will keep it if it's going to be clever, have blue eyes, good looking. You know, I don't know. It will be interesting to see how that moves forward in the future." (Ivy 315-323)

Ethical principles of respect for persons may instil practitioner rights, enshrine them in policy and support them in the courts, but that is not to deny the distress associated with terminating a pregnancy,

"We have training from people like ARC and they categorically say how important it is that you maintain your professional identity because the first thing they say in that situation is 'What would you do?' and they Categorically tell us to say, 'It doesn't matter what I do – we are talking about you...I can give you information, I can send you to other areas to get information, but, at the end of the day – the decisions you make are the ones you can live with and what's right for you. You are the one in the situation where it's happening. That's something I have tried to be very conscious about." (Laura 141-147)

Particularly for those participants who are mothers or who have experienced pregnancy loss, attitudes towards abortion are inextricably linked with attitudes to disability. It follows that the mental traumas associated with applying a moral compass are accentuated in the 're-lived' experience. One of the most personal accounts comes from Francesca,

"We lost a little boy at 32 weeks. My family, struggled with my ability to do my job…They think because of my personal life experience ... I couldn't take that step back, and not think about me, when I'm seeing these women. You know, it was a little bit like, well, you, you've lost a baby - how is it that you could support these women to terminate a pregnancy? because it's not about me … and that's very much how I feel about CO: to the midwives that feel strongly enough about this subject – "Well, that's great". That's on you, you know, if you feel that strongly about this subject, and you feel the need to take a step back, that's fine, that's OK, because that's your human right." (Francesca 49-57)

Many of the dilemmas associated with antenatal diagnostic testing parallel those in abortion – what is the point of one without another? some participants appear to suggest. Whilst expressing empathy with her abortion-critical peers, Karen supports CO yet is still able to take a singular view,

"I'm finding it clear in my mind, if I think what I would have done with my pregnancies had an abnormality been picked up, because I did have screening…I was quite clear as to what I would have done....and I'm a midwife. Would that be frowned upon by others? I have friends who have affected children, by trauma, the effects of longstanding birth trauma, colleagues who have allegedly 'abnormal' children, if we are considering abnormality...erm their decision was to continue with the pregnancy whereas I have quite strong values on that: quite strong values, thoughts on how I would have dealt with it. But I wouldn't castigate anyone else who was in a position, making the decision, who would continue with the pregnancy, knowing they had an affected fetus. That's just my choice as opposed to somebody else." (Karen 251-259)

The idiographic nature of moral reasoning, emphasises how subjective CO choices are,

"You've got to consider everything else, the rest of your family, the siblings. There's a much wider picture – it's not just about yourself dealing with abnormality or affected children. It's a personal decision only you can make. Lots of people can give their opinion, to try and sway you. The idea is to give women the whole picture – good and bad – give them a full picture." (Karen 259-262)

She acknowledges other stakeholders, but bodily autonomy is paramount, so being the prime moral agent, she is in control of judging what is in the interest of the child and whether theirs can be considered 'a full, full life' ahead.

6.3.2 Living a Full, Full Life

The most common genetic condition Trisomy 21, or Down's syndrome, elicits the strongest reactions amongst participants debating,

"For instance, with Down's syndrome, where you know, they can go on to lead and have a relatively normal, full, full life (with great emphasis) and you know…I've got friends with children with Down's syndrome and they're very, very passionate that they … that should not be a reason to terminate." (Betsy 112-117)

Generally, participants are more sympathetic towards abortion in life limiting cases and Peter explains why,

"I don't feel comfortable terminating a healthy fetus, or shall we put it, 'a potentially healthy fetus'? But I feel more comfortable with one that's gonna die anyway, you know? Just kind of making it less traumatic for someone so it feels a bit more comfortable, maybe?

***Interviewer:** and for the fetus?*

"Yes, and for the fetus (hadn't thought of that). I guess potentially, there's one dilemma there. I'll give you an example. I was asked to go and look after a couple. She had been diagnosed with, her fetus, baby, had been diagnosed with Down's syndrome and she didn't want to continue the pregnancy. So, I was asked to care for her, and it did sort of strike me that the baby, the fetus (whatever terminology you like), was compatible with life. I know people who have children with Down's syndrome and live happy, healthy, fulfilling lives, very much wanted and a part of a family. So it wasn't that this baby wasn't incompatible with life, it was not the family that this couple wanted or felt able to support. So that was quite a sort of a grey area." (Peter 188-195)

Thinking of abortion as being complicit in the taking of a life, gives a moral element to the participation. Some may query on what basis a congenital condition acts as a variant to trying to balance the wishes of the pregnant person with predictions of fetal outcomes. Betsy, Ivy, Karen, Laura, and Jane's data are rich in examples of different scenarios where congenital conditions may impact on CO decision-making – a minefield of differential diagnoses. Laura enlightens us on how life limiting conditions still are reasoned to have a quality of life and value in that life,

"People think we shouldn't have the power to say who lives and who dies. Erm, and for whatever reasons, whether it's a handicapped child that does not have a full life ahead … I mean, in screening, when we've done lots of training … about, say, how the Down's Society felt as though it was a crusade against them; that the object of obstetricians and gynaecologists was to rid the world of any person who had Down's syndrome. That didn't deserve to be in the world along with the rest of us. And certainly, that's not the case." (Laura 123-133)

Laura talks at length in an impassioned way about how the decision to terminate ought ultimately to rest with the service-user, despite these dilemmas. According to the tenets

of bodily autonomy, the service-user is entitled to control what happens to her own body, self-determine her own destiny and her child's future. The insight she provides as to whom the fetus 'belongs' and where propriety over life lies, is illuminating,

"We've had parents who have had babies … with a limited lifespan, and what they can do with that life, I have listened to them and thought, in the case I am thinking of where the child lived till, they were 7, longer than expected, I thought, 'well, that Mum was happy that that child could smile but couldn't do anything else'. The child was in a wheelchair, the child couldn't walk. Couldn't talk. Needed to be fed with a tube. I just thought, she was happy with her decision, she loves her child, but I knew, if I was faced with that, I couldn't do that because I already had a child that was normal, met all the milestones, and stuff. I just put myself in their shoes and thought, 'Well, me, I couldn't do that'. The shoes of knowing that my baby had Patau's or Edward's syndrome and that was the life it had. I would say, I am Catholic, but I would say for me, living like that isn't living…have we got the right to choose – who lives and who dies? For my child, in that situation, yes, I think I have." (Laura 133-138)

Laura is quite clear in distinguishing between her professional responsibilities and her personal perspective, though she makes sense of one lived experience influencing the other. The self-questioning midwives go through is personified in the later framework (see Table 8) which vocalises the main tenet of the thesis: that accommodation of CO is a worthwhile concept: facilitation of rights, suitably regulated and with limits does not penalise those whose circumstances or choices differ to objectors' own standpoint. Moral reasoning in respect of dealing with increasingly complex cases are highlighted by Jane as a calculus,

"I am just kinda thinking, it's just under 24 weeks, you'd be starting to anticipate that, 'yes, there would be some morbidity, but survival would be fairly high'. Chances of survival fairly high. There may be some morbidity issues but then when you're getting more towards 23 weeks, it gets to be just more difficult…I would support whatever decision that woman made, at that time" (Jane 400-406)

In the same way as a congenital condition can shift the parameters of the abortion decision altering the circumstances in which CO may be seen as a good or bad thing, now extreme prematurity will be examined as another criteria impacting on moral reasoning.

6.3.3 Medical Marvels At 22 Weeks

Closely bound with arguments of potentiality and ideas of when life begins, that the age of viability is constantly being redefined shifts the conscientious objection balance in the midwives' minds (i.e. if the 'abortable fetus' is resuscitatable). Based on calculating risks, midwives negotiate with their inner voice. Predictions of survival supported by scientific advance are evidenced in the data as the PET: 'Medical Marvels at 22 Weeks',

"That sort of dichotomy because you have the legal side of it and you also have your own personal, religious, (whatever) views that: it's a living cell, life as you know. Life will find a way kind of thing and it's because of that and you are here to support and promote life and make sure every life has a good outcome. Looking on the flip side of it, doesn't marry up. What's your own beliefs...if your own beliefs are going against what the legal definition is…of when life started or when life can be sustained. Then you have these medical marvels of 22 weeks or such who survive and become babes. You know that sort of thing, so it's how do you balance and weigh up all of this?" (Gillian 83-91)

Professional dilemmas centre on what Gillian here calls midwives' duty "*to support and promote life and make sure every life has a good outcome" (85-86).* Whether this is contradicted in abortion is a matter of personal preference. Ancient philosophical teaching combine with contemporary thoughts around survival. There are exceptions to legal rules, pushing medical and gestational boundaries,

"Because, the thing is, if you think about it, it's one thing to think about it in a kind of theoretical realm and another to experience it viscerally – that may lead to a degree of trauma which you think, 'I thought I was ok with it but now, I am not because I saw that baby come out and move,' you know, and it became a real person, I suppose. If you have delivered babies at 16 weeks, even, you know? There's life there. And then it's really hard because they're not viable, but they're not just a clump of cells either!" (Peter 100-108)

6.3.4 Conscientious Objection Crises at the Cusp of Life

Both Jane and Betsy's accounts of extreme prematurity, converge on this point: that advances in medical science may well have resolved issues, but created new challenges in doing good,

"I think fetal medicine is constantly developing. I would rather use the word developing than improving. (Laughs). I think we've done amazing as far as lifesaving goes – but has

there been enough consideration for the morbidities? …. (When her) waters went at 21 weeks gestation…she was absolutely terrified, thinking 'if I get past 22 weeks and 3 days (or whatever it was), then (she) couldn't terminate'. She had no powers there. She couldn't defer. There's that little void there, where we have (well, medicine has) lowered the gestational viability to 22 and 6. We don't resuscitate... but there are individual considerations around that gestation." (Jane 380-388)

Where Betsy and Jane's accounts diverge is in timescale. For Betsy, acute mental trauma is further accentuated because the baby is born with signs of life. It is a split-second crisis, a timing dilemma, Consequential ethics, which look to the outcomes of one's actions, come into play in the long-term in a precarious balance of virtues,

"Am I doing more harm than good? …absolutely…absolutely. Then you're at that comparable point… to that lady who's making a decision to terminate. Does the medical profession, you know, say.... I remember a particular midwife once saying, 'She can't terminate now' erm and 'we are at that brink of resuscitation and at that point – what will be, will be.' Completely out of the woman's control! If it was a disabled fetus, she would have a choice to terminate. It's hard...." (Jane 391-400)

A resuscitation dilemma then ensues for midwives who recognise the lifelong implications and do not wish to inflict suffering on the baby and family by their instantaneous clinical-decision-making. Obliged by law and professional guidance to commence advanced newborn life support, this is not to remove the complexity, the emotional fallout or moral conscience burden. In the absence of policy, midwives are never quite 100% certain. When, as in this example, the professional's outlook does not align with the service-user's – disagreement irretrievably and detrimentally breakdown therapeutic relationships. Conflict within the multi-disciplinary team further complicates the midwife's dilemma. Karen likewise has lived experience of CO crises at the cusp of life,

"We've had fetuses that have shown signs of life, then it's all about what support do you give: I mean, is it a gasp or is it an actual breath? People misconstrue different things. Probably years ago, fetuses prior to the cut-off for gestation, well, the cut-off for life, if you like, were probably taken away from the mother and just left and not observed. But I think now, we are very much in the frame where we observe the fetus and get the mother's involvement. Irrespective of what's actually happening, they're more involved so that the view that you would pick up on things, that you would deem to think that there were signs of life. We have had many discussions about 23 weekers, that have

showed signs of life and whether they should have been resuscitated when the paediatricians have said, 'No! Not for resuscitation! We are not doing anything'. Making quite a categorical decision, so that then a Coroner needs to be informed." (Karen 345-354)

Like Gillian, earlier, who more advocated participation in an emergency to preserve life, Betsy voices a crisis relating to new-born life support,

"The way in which erm erm the termination process takes place. Sometimes babies are born with signs of life, so you have to, you know, the legal aspects of that, although they are.... You have to be registered as a birth and then a death, erm... depending on the viability age. So yeah, there's a whole ream of things to consider in that." (Betsy 395-399)

Being in two minds with dilemmas leaves professionals feeling disconcerted or *"torn"*. The analogy put forward by Gillian is wearing two hats.

6.4 Theme 4 - Being Torn Between Wearing Two Hats

Typical of reproductive health dilemmas, which feature concern for the outcomes of two lives by the nature of being pregnant, this theme pits woman-centredness versus fetal rights. Ivy states,

"It's really difficult, isn't it? Because you know, we haven't or we hadn't seen so many cancer cases as we have recently, but unfortunately to save a mum's life, the best thing to do is to take baby's life, which is a blunt way of putting it, but it is, isn't it? But then what happens if that baby comes out breathing?" (Ivy 170-173)

Midwives may be caught in the middle of the dichotomy, trying to balance obligations to fulfil patient wishes, with dealing with the vulnerability and limited status of the unborn. Expectations do not necessarily atone to midwives' own definition of what the job comprises and what midwives ought to do, Gillian suggests,

"Yes, when I first started in my midwifery career. Obviously, it's one of the things that I was torn with a lot was about the rights and wrongs of abortion. Because I'm a practicing Roman Catholic (and all the rest that goes with it) so that was a sort of how should I put it? Something that I had to ponder on a lot." (Gillian 40-43)

In gauging whose rights ought to take precedence, midwives may attempt to respect autonomy, but question where that leaves the midwife's own rights,

'I've come across sometimes as well where midwives have said I am conscientiously objecting - I don't want to go in there. And then, other midwives have said, well, you know, you're a midwife and that's it!" (Betsy 104-105)

Facilitating a satisfactory experience on behalf of the employing institution may yet raise a conflict if incongruent with personal values. Midwives may ask – 'How best to manage scenarios that do not, uphold the same ethos around valuing life?' One of the coping strategies for dealing with this is described as 'Putting Things Into a Box'.

6.4.1 Putting Things into a Box

Gillian first described the term "*two hats"* as a depiction of midwives' dual medico-legal roles – wearing an operating theatre cap or lawyer's Tie wig. Alternatively, she refers to a combination of professional code and personal ethos,

"It's something that I don't wanna say: I give up what...my beliefs - but I think I've sort of learned to put it somewhere in a box while I am caring for somebody and taking their opinions and their thoughts and feelings and what they're going through into consideration… It's almost as if you're wearing two hats. If you like I've come to work and I'll do this, but this is what I believe kinda thing." (Gillian 66-70)

The idea of separation, or compartmentalisation, is expressed widely in the data as a coping strategy, boxed in a Pandora-type scenario, where feelings are put on hold,

"In this country, the fetus doesn't have rights…so I suppose I can mentally compartmentalise, that and the woman is my patient so it's very clear in my head. May not be to others ethically…Maybe around my own moral code with to do with my religious beliefs. … I can compartmentalize that when it's a medical termination, erm? Strangely enough, because it's still a termination, isn't it?….I'm very good at putting things into different perspectives, well, into boxes…in my own brain." (Betsy 233-239)

Betsy doesn't expand on what things she as a midwife may be trying to suppress, how, or whether she achieves it, but the passage does seem to signify there is a place for one or the other in storage with clear, unsurpassable boundaries. Jane distinguishes between two personas, one, scientific and role-based, and another which is ethereal,

"I suspect it could be a bit of both. I suspect it would be more of a personal belief. I suppose we are all products of what we have experienced in our lifetime, erm, and I suppose it's down to an individual as well, on their character and whether they can compartmentalise a professional persona away from a personal persona. I suspect it would be a combination of those two." (Jane 31-34)

The latter is focused on the semantic - 'what makes me, me, or makes you, you': pre-understandings, assumptions, attitudes, and beliefs, all highly subjective. These influences amount to a highly individualised 'lived experience of dilemmas' which reflect upbringing and personal circumstances. Jane appears to be saying here that lived experience of dilemmas is a component of midwives' stand on CO – and that expression of freedom of conscience is opportunistic rather than pre-determined. She respects the alternative views of her colleagues but adheres to the rights to self-determination above any consideration of midwives' morality, however. Her views as a professional circumvent any semantic response she may feel as a RC: a practising midwife, practising religion yet a non-objector. According to Jane, all have bearing on conscience-based decisions. In the course of employment conduct decisions are less than smoothly guided,

"Every practitioner has their own life experience, don't they? They may have grown up as an adopted child – and all throughout their lives thought, 'Well, I was never wanted'. Do you know what I mean? They may have had miscarriages or terminations themselves. Lived in domestic violence situations. It is very difficult because we are not robots." (Jane 153-156)

How best to defend a different position, recognising one's own needs but fitting in with employer's, professional or institutional expectations is somewhat of a juggling act. The demarcation is not always well-defined,

"*Putting on the uniform - behaving in a professional way is what the profession needs you to be - as well as what the woman needs you to be." (Betsy 77-79)*

Duty is denoted by the uniformity of the garb – standardised, impersonal, and rigid which contrasts to the rather more subjective inner self: one that is sentimental and sometimes uncomfortable to divulge. Impassioned feelings are put to one side. Detachment is one way of exhibiting resilience to the awkwardness that participation raises,

"Although I am pro-choice, I would choose not to do that job every day. I couldn't do it because I think it's…to become detached. I don't know whether these women or these practitioners had become desensitized. It's just a procedure. Maybe it's their way of coping with it. I think that would be a very difficult thing to process. At the end of the day, or to leave behind you." (Diane 145-148)

The onus is on the practitioner being called upon to be sufficiently flexible enough to fit within organisational operations and declaring objection early is part of accommodation. With a tone of admiration for objectors, Catherine explores the notion of avoidance,

"There is a part of me that would wonder 'how much of this do I declare, or do I just spend a career trying to dodge caring for that woman by saying I don't feel well or I'm busy? Or can I be allocated this and this?' It takes a strong midwife to actually be able to formalise it. I think there are lots of midwives that probably sit, not with a conscientious objection, but more an ethical dilemma and they don't give rise to that, because they recognize the woman needs a level of care." (Catherine 222 – 227)

6.4.2 Ensuring the Patient Comes First

Conscientious objection is understanding that there is much more to the concept or autonomous practice in employment than getting paid for one's technical skills. Divisions of moral culpability with the patient afford midwives an opportunity to sleep with a clean conscience.

"*I just feel it's up to the woman, and that's her decision. I can understand why people might object, you know, you can see that the woman's having frequent terminations for non-medical reasons, I suppose. That doesn't sit comfortably with me. But again, it's still up to her, whatever she wants to do with her own body. If she feels she doesn't want to have a baby, that's her choice." (Anna 121-125)*

Despite the assertion that allowing practitioners to exercise conscience is in society's best interest, the practice is not equitably witnessed to consider the midwife's perspective,

"I think…the midwives probably compromise their own standards or their own beliefs or their own ethics." (Catherine 182-183)

In facilitating patient wishes, meeting requirements of the job description is simply getting the *"day job done" (Jane (361)* and *Laura (45).* Again, put to one side, objection

is boxed off, avoided, ignored or minimalised, superseded by the over-arching needs and wishes of the service-user,

“I think it’s personal choice and my position is that it’s not for me to decide what people should and shouldn’t do with their bodies. As a midwife, that’s at the core of what I do. It’s facilitating bodily autonomy. As difficult as I find it (because I don’t find it easy), it’s for me to make those decisions- that I will support people as best I can. I don’t know what has brought people to those decisions where it’s almost not my business. I just have to be professional and supportive.” (Peter 117-122)

Like any other practitioner may do, Peter takes self-determination into account but notwithstanding, the limits of their freedom of conscience are determined by gender,

“I’ll never be in a position where I have to make those decisions and that’s quite a privileged position to be in. So, I can’t. I feel that it wouldn’t be acceptable for me to have a CO, really, how could I justify that, having been admitted to the profession? As a man, how can a midwife turn around and say, ‘Actually, I think this is wrong,’ you know, it feels an untenable position.” (Peter 121-125)

Whilst all participants remain sympathetic to objecting (and arguably conflicted) colleagues with different views to their own, they still predominantly support woman-centredness,

“I suppose, if you are part of midwifery- then a lot of focus is on the woman and should always be on the woman. So maybe, I have already made that choice. I feel like I have already made that choice before.” (Maria 59-62)

The main concerns are for the acceptability of CO to a service already stretched, staffing sufficiency, abortion coverage and the functionality of the team.

6.4.3 Respecting Differing Views

Reflecting the seniority of some of the participants, useful insight is provided into support and managerial supervision. Potentially, approachability of the Professional Midwifery Advocate (PMA) can make a big difference,

“So, things like resilience training within organisations occurs and that would benefit individuals like you say. Professional midwifery advisors. Now their basis is about resilience and about 1 to 1, about actually keeping people in the workplace…. So, if I

had a magic wand and I wanted to improve anything, I would have it as part of the resilience discussions. Those regular PMA sessions. And even just awareness giving So, you pay PMAs, wander around with a lanyard saying 'I'm a PMA'… The teatime chats I do meet and greets things like that. It could be part of those just general conversations. There are processes for people who want to object. Do you understand what that means? Do you understand within your practice?' The limits of it. Some people will feel it's a very specific: 'I can be involved in this' and not theirs or the wider. Uh, supporting of somebody I do feel uncomfortable. What can I do about it?" (Catherine 331-345)

Anna thinks this too, rather than "*just battle on alone" (Anna 306).* Working together has implications for all aspects of safe care, including moral decisions because its forms part of the checks and gauges of abortion provision. There is convergence with Betsy's testimony on this issue – fair allocation (212-215), confidentiality (48-53), recognising boundaries (271-274) and an acknowledgement rather than assumption of CO (446) all part of the way she deals with objectors. Betsy's fair and empathic approach comes to light when again she reflects on fairness,

"*I would never ask somebody to do something I wouldn't do myself." (Betsy 256-7)*

Betsy, further, provides a balanced view of the accommodation middle ground,

"Respected - that's what I see. I wouldn't judge somebody for saying, you know 'I can't. I can't do that. I can't provide that, that level of care - I choose not to please, you know?' 'cause? Like I said, I've dealt with that when someone said 'Please, can you not put me in that room?' And I have not even probed because that person has asked me, asked something from me and I need to respect that." (Betsy 212-218)

Like a CO-pressure valve, judgements are rendered so much more watertight if in unison. Mostly there is an acceptance of colleagues who defend their right to freedom of conscience and other team members defend that right vehemently too. Although tolerant attitudes may vary in the data, sharing the decision-making is seen to promote safety, maintain standards and guard against criminality or unethical practice. It shares the weight of conscience burden. Incongruent views mean declaration has implications for the smooth functioning of the multi-disciplinary team,

“Depending on what their role is I would question if they’re in the right job, particularly. I mean, I would question if you needed to conscientiously object, are you in the right job?” (Anna 245-247)

“*Yes, I do believe people have the right to conscientiously object. I might not like it but I do believe they’ve a right yeah?” (Gillian 145-146)*

Building consensus, learning from one another, and gaining a mutual experience contribute to developing moral reasoning, data suggests. Even considering the perspective of the service-user is advocated,

“We’re involving women in the change process and in decision-making from a very early onset. With Trusts, it’s going that way – and it needs to, for very good reason: to involve all our service-users in the process. It’s a definite good thing to happen is to involve all our service-users in the process.” Karen (98-101)

Without jeopardising safety or inconveniencing the woman, who ideally should not be made aware of the non-participation of staff, delivering the right care means being rights aware. Data suggests healthcare professionals do not always follow RCM recommendations on best practice,

“I…. We would say professionally the woman should be unaware of CO. In reality - I've seen complaint letters for women who feel they have been treated poorly because they have felt the midwife didn't support their choice. So, in a managerial capacity, I've had to respond to complaint letters where women have said…. they were difficult choices. The care, while clinically effective, emotionally was unsupportive.” (Catherine 250-254)

Sometimes, the evidence is clear and concrete – when it comes to CO, there are instances when staff don’t always get it right in achieving a positive patient experience and providing the support impressed in their professional guidance. Using policy is less pertinent than when faced with a CO crisis at the bedside where dilemmas centre on ‘Being a Midwife in the Room – What? When? Who Should I Tell?’

6.4.4 Being a Midwife in the Room – What? When? Who Should I Tell?

For obvious organisational reasons, the importance of early declaration is reiterated, a central tenet of transparency and openness. Where this isn’t always happening practically, skirting around the delicate subject is contributing to misassumptions about participation capacity,

“I think the staff need to object quite early in their career or employment, so, I think there is still difficulty if you object on the day ... there is a pull from the workload infrastructure versus the individual’s need. If somebody is going to object, they need to do that as part of their ‘employment induction’ if you like, and I think if they were to object, at a given moment in time, they would find it hard. They would find some sensitivity. But it will be met against service needs. So, although you would take them out of the absolute clinical contact, they may still be a ward-based environment where for that procedure all that care is still being given, so, they couldn't remove themselves on the day from the clinical environment.” (Catherine 92-100)

Handover dilemmas point to disclosure difficulties – who do I tell about my CO, what, where and when? What are the implications for my colleagues when faced with a CO crisis or conflict at handover of care? At what point should I say, ‘Look, I don’t want to go in there’? ‘Where do I find support?’ Unlike Catherine (who suggests the best time to declare objection is at employment) Maria views the point of handover to be more opportune,

“When you take your patient- before you even take your patient. Handover, maybe? If they handover that this is happening, or this has happened...or anything like that. At that point they should say, ‘Look, I don’t want to go in there.’ I suppose it’s being brave in front of the team but if that’s how you feel, then you should be voicing it. Before you even go near your patient.” (Maria 185-189)

Peter also recognises that the unpredictable Maternity workplace may pose certain challenges. She tells of CO in action, when unexpected CO questions may be raised in haste,

“It’s seven o’clock in the evening, you’ve rocked up on Labour Ward thinking that you’re going to have a nice, normal delivery or thinking that you might be looking after the induction bay, whatever it is you’re going to do. Then you are told you are going to do this – are you okay with that? - all of those thought processes have to happen very quickly. ‘What’s the situation? What’s the scenario? Oh okay. Hadn’t really thought about that- oh! Gosh! – Don’t really know about that’, then you walk into the room....and you see the couple and see how distressed they are. You can just see it on their faces.” (Peter 209-217)

When asked about their rights to CO, Peter’s reply is forthright – reasserting midwives’ participatory ‘hands-on’ role,

“As the midwife, all I can see with an embodied experience of it, as a person (and we are talking about midwives in a midwifery context), is the one who has to walk into the room and do the deed. It’s different on gynae, doing D and C’s, or whatever, maybe the women themselves are actually taking the tablets. But it’s the midwife themselves who has to walk in and give the tablet, who has to deliver the fetus, who provides the emotional support. It’s that old thing, yes, you can think about all these things in theory, but you’re the one who needs to walk the walk. It’s that practice/theory gap. No disrespect to pharmacists, MSWs, obstetricians but it’s the midwife who has to do it. That’s where I sit.” (Peter 370-378)

The abyss between the separate philosophies of doctors and midwives is noteworthy,

“Coming at it from a midwives’ perspective, I'm not, I'm completely not ‘dissing’ my medical colleagues here at all. That's not what I mean, but the medics have a very different stance. They come at it from a very different angle. They complete the paperwork and counsel women, but we do all of the acts. That makes sense, so we are sitting with them, we give the drugs, whatever they've been prescribed, we are caring for them throughout that. That whole care episodes and post-natally and we are the ones that are actually doing that. And so, if the CO was coming from anywhere, it makes no sense to me that it's never.... midwives. It's not been understood that it could come from.... From the people that are actually doing the do. (Betsy 425-424)

As Betsy and Peter both urge calls for an inter-disciplinary re-shift in the balance of power, this incurs a rethink in decision-making. Peter suggests the current requirement for two signatories proffers some protection in an indemnity statement that further highlights the uniqueness of the midwife’s hands-on part,

“The Doctor can write the prescription, and feel a little bit far removed from it. They can sign the forms, maybe that feels like a bit more of a commitment (but at least there are two of them doing it and they don’t have to kind of see the consequences of that). As a midwife, you’re the person in the room, watching it, being there as the life ends. Yeah, so. it was just an interesting moment in my midwifery career where I thought: sometimes it feels straightforward and then there are other times when it doesn’t. That’s midwifery, isn’t it? Sometimes it’s just messy.” (Peter 230-236)

Certainly, conscience decisions can snowball, and the impact of the objection can be deep and far-reaching,

"Its about knowing your views. If you weren't wanting to participate in anything, then absolutely that needs to be declared from the very beginning. Everyone needs to be aware of that, because it impacts everything. That impacts on an emergency and a lot of stuff in healthcare." (Nancy 229-233)

Controversies largely centre on the fairness of workload allocations, ensuring safety and best practice – the right midwife delivering the right care – reinforced by legal provisos which will now be examined in the next theme.

6.5 Theme 5 - Two Signatures and the 'Escape Clause'

This GET refers to The Abortion Act and requirements laid out in four criteria which allow practitioners to terminate pregnancy. More specifically, it elaborates further on section 4 (i), called by Gillian 'the escape clause', which makes provision for those who decline to participate in abortion procedures, for whatever reasons. Midwives' understanding of human rights conventions and how this relates to policy are also included. Generally, midwives are impassioned about the rights of women[2] but infrastructure to frame human rights conventions are viewed with caution as something feared or used as a punitive stick rather than a blueprint. There is a lack of clarity in understanding about the basis on which abortion is permissible generally and some midwives have never heard of the conscience clause. Midwives predominantly ask the following question:

6.5.1 Is It Legal?

One of the gaps in knowledge identified in the research is to what extent midwives know about their rights and conversely their responsibilities/obligations under the Abortion Act, though there is widespread appreciation of the reasons for a second signatory.

"I think the two doctors bit was to protect, I kind of agree with that…so it is for those two doctors…but the flipside of that is that it would protect against one doctor being…(unethical?) yes. It would stop one doctor being influenced by wrong reasons. So, actually it protects the woman, it protects doctors themselves." (Jane 271-280)

Overall, there is support for the Abortion Act,

[2] Other rights are mentioned in data including racial equality, gender, employee, paternity, and disability awareness.

"I do like it really." (Jane 181),

"I am probably in the middle because I wouldn't like to think that it was done as a matter of course. There has to be serious consideration and it has to fit inside one of those four categories…. However, I feel that there are 4 criteria – we've already got the guidance, erm, and I think it supports what we currently need." (Karen 183-189)

In comparison to other medics, only Karen picks up on the Abortion Act's lacking accent on the midwife's perspective, amongst whom there is a pioneering sense of objectors' politicisation. All maintain a commitment to see justice and fairness enacted with a compassion and sincerity credible of any professional midwife.

"I think if you take away the strictness of it, then it may lead to more interventions that shouldn't have happened. You know, you don't want it abusing: the system of unwanted pregnancy. If they feel they can abort a fetus, it shouldn't be as freely available as that." (Karen 184-187)

Regardless of their own stand on conscience, they support the rights of dissenting colleagues to object. To this end, overall, midwives' opinions on the Abortion Act are supportive, mostly believing that the current law sufficiently protects practitioners and maintains public safety,

"_Like I say: the onus is on the midwife. If somebody's got strong enough feelings, they haven't happened overnight, so, I think the law is good <u>enough</u>. It gives an outline of what you can expect, and it absolutely puts the onus on the individual. But if you feel so, strongly, you will have declared that in the early part of your employment, or career, whatever that might be." Catherine (200-205)_

Peter views progress to be as a legal initiative: the way forward to be in midwives' employment as co-signatories. He breaks new ground and challenges antiquated practices yet is wary of making reactionary moves which may create further confrontation. In treading the fine line with abortion-critics concerned with abortion ease and timing,

"It is interesting why does a doctor have to make that decision? Could a midwife make that decision? My impression is that it is pretty tokenistic, really. My impression is …is that if you want an abortion, it's not difficult to get. But what that experience is for the person who's trying to get it, I don't know. Whether we should make it easier? I don't

know. Who gets to make the decision and why? Yeah, I can see that it's problematic, but I guess there needs to be some sort of process to ensure that people are given the chance to think and reflect and understand what is involved and how they feel about it." (Peter 206-213)

Gillian is more critical of flaws, reflecting more on the cons as well as the pros from a historical perspective. She sets the 1967 scene, elsewhere referred to as "*Call the Midwife"* times by Ivy *(133-134)* and orientates the reader to the contemporary debate,

"So, the Abortion Act then was, to me, based on what was current then. But now we have so much advanced medical technology and all the rest of it, that you can detect things, earlier rather than later, or whichever, so probably it needs to come up with the times and match it was when it was written. Then it matched the times, you know? for that time." (Gillian lines 286-290)

Using her two hats, limitations are well recognised by Gillian, who has a clear appreciation of the legal issues,

"It wouldn't (offer protection) as any law goes. I don't think it offers complete protection. It's a guide. I don't think it offers as much protection as we think, because people do what they want to do. Uhm? Protection in terms of the medical arena? Yes, because you have that leeway for medics to do a medical procedure. For the woman? to some extent." (Gillian 387-390)

Having applied a contemporary lens, medical advance in neonatology and a changing scope in the age of viability are at the heart of the need for review,

"You know with timing; we all get our timings wrong. Uh, what happens after that stipulated time in the law? I suppose it depends. Maybe that's why I'm thinking it probably needs a review to bring it into the current climate. I don't know if it protects, because if it did, what happened to all those people in the sixties? You know, early seventies. We're fragile. Despite the law, we've had loads and loads of, you know, horrible outcomes." (Gillian 391-395)

Although flexibility may be desirable, problems arise with its intersectional inconsistencies. The "*protected specifications"* (an overlap from other legislation) for some people are not realised, she suggests, so safety risks being undermined if care

becomes discriminatory. The engendered use of language appears in Peter's transcript, driving home a liberal feminist point,

"I guess my area of developing expertise is around gender and I can see why it's termed engendered. When you mentioned gender, I can see lights go on in my head! To see how this is kind of, the system controlling who gets to access this and all the rest of it. I can see some issues around that but, by and large, it seems to me, broadly speaking, that there needs to be some tweaks making." (Peter lines 219-223)

Visionaries of the 1967 Act were concerned with the prosecution of back street abortionists, which have in the UK since been eradicated. A lot has changed to reconfigure the environment in which healthcare professionals practice,

"Maybe they need a review. It is very patriarchal…in the language…It's sort of outdated, really, in terms of what's happening currently, so perhaps it probably needs a review…I would have thought so, but I think when it was first coined.....I suppose in a way we were trying to protect women because it becomes really dangerous when you try to do an abortion after 24 weeks and it should be like medically led...for medical reasons, so I suppose in a way it was in place to help woman…We've had many laws that have been reviewed recently, and we could maybe with this one. Maybe this is one of those that should be reviewed within the current climate." (Gillian 362-370)

6.5.2 Understanding the Conscience Clause

Section 4 is highlighted by Gillian as one area of 'The Act' that does not fully address the needs of midwives, since it is midwives who currently personify the lived experience of the ethical dilemmas. Evolving attitudes to CO are voiced through a midwife's lens, advocating a new departure. For Gillian, compared to doctors' rights,

"It should be the same. I don't know why it would change the decision making that change? If the doctors are forward in this like that sort of an 'escape clause', if you like. Uhm? To some extent. Midwives do have it because I've heard it said in my practice. You know, that you can conscientiously object. Not, not in so many words, but because your colleagues were aware of your belief system, you'd sort of .... that's sort of not put you into that position. So, it's not a written clause for midwives to say you can.... You can declare and not participate, but then it gives us into that, we, we run the risk now in our own medical practice in terms of it's an emergency. Why would you not try to treat

and save life in an emergency? Even though it means the loss of one life, but it's an emergency." (Gillian 409-417)

Whilst for midwives, CO may be tacit and implicit, medical emergencies make CO crises even more acute and ad hoc. The rapid and unpredictable nature of Maternity environments mean that,

"(laughs) yes – you never know what's around the corner!" (Nancy 146)

Even in these kinds of urgent scenarios, however, practitioners are steered by their professional guidance, as much a part of ethical decision-making, as clinical. Betsy picks up on this,

"I'd probably find it quite fascinating to look at the laws around that... From a doctor's point of view, the GMC is quite…ethical…I would imagine it's 'do no harm', isn't it? And you're there to save a life." (Betsy 171-173)

In all accounts, rights to life rank above rights to freedom of conscience, thought and religious expression but this is not always the case worldwide:

"*Great Britain is clear…If we lived in America, the boundaries are very different, because the fetus has rights, doesn't it?" (Betsy lines 230-231)*

Presumably a reference to the decision by the US Supreme Court to overturn Roe versus Wade on June 24th, 2022.[3]

This now holds there was no longer a federal constitutional right to abortion. Similarly, Peter is no less conciliatory about the global situation, viewing CO as a *"slippery slope":*

"You can see what's happening in America. It's not difficult to rewind people's rights given the right cocktail of circumstances and then if one of those triggers is a murder, it's one of those trigger issues. If you start revoking the right to abortion, then it's a slippery slope. You start travelling backwards. It's not difficult to imagine a link between that and

[3] **Roe versus Wade** (1973) was the US Supreme Court's landmark decision that ruled that the Constitution of the United States protects a pregnant woman's liberty to choose to have an abortion without excessive government restriction. In 2022, the nation's highest court deliberated on *Dobbs v. Jackson Women's Health Organization*, which regarded the constitutionality of a Mississippi law banning most abortions after 15 weeks of pregnancy. Lower courts had ruled the law was unconstitutional under *Roe v. Wade*. Under *Roe*, states had been prohibited from banning abortions before around 23 weeks—when a fetus is considered able to survive outside a woman's uterus. In its decision, the Supreme Court ruled 6-3 in favour of Mississippi's law—and overturned *Roe* after its nearly 50 years as precedent.

what's going on in Afghanistan, I mean, these things happen. They happen. I feel kinda cross about it." (Peter 159-164)

6.5.3 A Fresh Look at Conscience Policy

This is an example of how policy aimed to standardise care, communicate best practice, and provide an evidence-base, can be entirely over-turned. Policy protects practitioners and promotes safety for the public, but reinforcing CO policy is less well defined,

"It's really difficult because if you start creating strict guidelines then you almost force being there, they've got to be policed then, haven't they? Then that can almost create a lot of ill feeling and, sort of, force the politics out like you see in America, where people become politicised by having to make a decision one way or the other. So, it's difficult because everyone likes to have clear understanding of the world, let's be honest. My understanding of the world is that it is a messy place and sometimes you've just got to have erm, do as best you can...but that doesn't fit well within the NHS, does it?! We all like a guideline, we all like a policy, makes us all feel comfortable and that's obviously going to make life better for everyone." (Peter 517-525)

The practical ways midwives make clinical decisions, in the absence of formal policy calls for innovative entrepreneurship. Some staff would not know where to go for help though a few ideas are put forth. Intranet facilities on 'the hub' provide a plethora of useful resources, line managers and so on, are mentioned but no conscience strategy of employment features at all. Even if there was guidance, not all participants are convinced it would work because of its inflexibility,

"Yeah, and what might be right for me today might not be right for me tomorrow." (Maria 36-37)

Applying policy would be a familiar way for midwives to find out what to do, if faced with a quandary in much the same way as any other but Gillian, is doubtful of its usefulness in application,

"I can't see how it will (make things easier sic). Because you would have your own policies and guidelines within the organization of what you have to work to, and you're supposed to sign up to that when you. Join the profession and joined the organization. Whatever the policy and guidance are, I think we also have that because I know we've had that drew in my.... if you objected to certain things. You know, it was sort of like support in the clinical area. You would not be given patients or put into that position

because of your beliefs…. You were sort of accommodated, if you like so, and I'm not. I'm not so sure whether you would find a policy would say anything." (Gillian 239-250)

Peter criticises policy as prescriptive. The idiographic nature of moral reasoning, calls for greater flexibility and independence, not less,

"It's getting people to think through these challenges and processes – these are the leaders of the future! They will have to be dealing with all these policy changes. I think it's more radical to start there rather than to tinker about with existing frameworks. Let's get them to think more expansively about what it means to be a woman, or a pregnant person, or to exist in a really complex and messy world, rather than, 'What does the policy say? What do the guidelines say? What does this textbook say? Then I will do that', rather than, 'Then I will do that,' I think there is that mentality and need to stop that." (Peter 534-540)

In many ways, CO policy was not on participants' radar. Until interviewed, few had formally considered the topic, except in circumstances of rape or abuse, and none took the stance openly of an objector,

"It's all to do with, the fact that ok, when a man can get a woman pregnant, but It's the woman who has to carry the baby, look after the baby. When a baby is born, when It's older. It's a lifetime commitment, for her. And if she feels that that's not right time in her life for her, to do that, then I feel that that's her decision. Especially when you're thinking about it could be because of rape, or abuse, when It's been very difficult for her." (Anna 73-77)

"When we look at the society that we're in and men can reproduce and then say I'm going to walk, walk away from that and never, never have to care for it …. Until they have the same responsibilities … and it has the same impact on your body. It's never going to happen, but that's never. That's never the way it's going to be. So it should be, it should be a woman. They also have a right? So, to you know. Make sure that they don't impregnate somebody that that." (Betsy 483-486)

"Where does that choice end? I don't, I don't know, but I think it. Ultimately, it's the woman's choice." (Diane 197)

***"**Every woman in my opinion has a right to choose" (Francesca 33)*

“I believe it’s the woman’s own right, to do whatever she wants with the pregnancy...erm, as I say, I’ve not come across it in my career yet where I’ve felt I needed to object to anything. But yeah, I do believe that it’s the woman’s right with regards to whether she wants to go down the route of abortion...….I do still believe that it’s the woman’s right. Erm, but a late gestation, depending on the reason, I suppose is a little bit more difficult...it’s hard at a later gestation. I want to support somebody in their choice, but I don’t think that I would conscientiously object to her decision.” (Nancy 26-3)

In facilitation of these rights, the midwife’s role as advocate, facilitator and support is hereby compounded,

“*I'm very passionate about women's choices and advocating for women. I'm very passionate about supporting women going down that that that road…” (Betsy 64-65)*.

That is not to say that there was little data on lived experience of ethical dilemmas relating to exacting policy. In fact, there were plenty examples of CO in practice, occasions when CO matters mattered to participants. The point being, conscience policy, whilst not a panacea for *all* ills, may go some way to alleviate the distress associated with moral reasoning and ethical decision-making. A policy formalising rights makes a system of appropriation more likely. Only then will accommodation of CO ensure ‘the right midwife, delivering the right care’.

6.6 Theme 6 - The Right Midwife Delivering the Right Care

The focus of this final GET is ‘getting rights, right’. Despite every participant’s recognition that at no point ought the woman’s care be rendered unsafe, or unkind, intolerance of differing views is still being communicated. Subliminal, implicit, or covert in Maternity settings, they report ‘sarcasm’, indifference and intolerance. The onus on midwives’ being ‘with woman’ yet under duress is one of the main contradictions of CO. Respect for differences and non-judgmental attitudes are put in the spotlight,

“I’m hoping that she would be respectful of anybody who had a conscientious objection, but at the end of the day, she’s there for a reason. It may not be an easy decision for her to make… so hopefully she’ll want somebody who’s kind and compassionate looking after her.... Irrespective of what their views are, they should be kind and considerate.” (Karen 221-225)

Although the focus of this thesis is the elusive phenomenon of CO through midwives' lens, there are plenty of predominant examples in the data of its wider impact on inter-disciplinary working,

"A Consultant - doctor - he could make the midwives actually feel quite intimidated, because he felt he was acting in the women's interests, and he didn't always have a regard for the midwives' interests." (Catherine 171-173)

6.6.1 Achieving a Harmonious Balance

The picture painted of the traditional objector is one of isolation, stigmatised and embattled,

"I suppose they could have meetings to have the discussion, as to see how she's feeling. Perhaps, support through meetings if needed it. Perhaps some support through occy health, if she needed it, rather than just battle on alone." (Anna 204-206)

If the demarcation between medics and midwives is complex, the segregation between objectors and non-objectors is one further division,

"I think if there were quite a lot of staff who objected, there may be problems or implications as regards workload, I think. Uhm? Staff thinking you know it's always me that goes in the Bereavement suite, so I should imagine that would make an impact." (Emma 179-181)

Peter faces her own challenges,

"Yet I feel there is a conflict there – it is an exclusively female profession, bar a handful of us, so there is a risk that if I come in...and being very visible as a man, say, 'I object', everyone scrutinises what you do. If you're a woman and you conscientiously object, then probably, it would annoy a few people, but it wouldn't become a big topic of discussion. It would just fizzle into nothing, whereas if I turned around and said it, it would become absolutely the talk of the town. It would become part of the debate about 'Who's he to make those decisions? Who's he to say these things? We have let him into the profession and there he is telling us what we can do with our bodies.'…. I feel like that in the situation where they said, 'Can you go into room 10? There's a woman who's come in for termination for, say, fetal abnormality', and I say, 'Actually I don't really feel comfortable with that,' I could just see the tumbleweed as everyone would just stop and kind of look and go, 'Wow!'. Does that make sense?" (Peter 128-143)

"It's quite Existentialist in my thinking but I think if you've got a uterus, and you are potentially going to carry a life, then potentially I think that does confer a different perspective on things. Whereas if you're someone who doesn't have a uterus and is a man - you're not going to be put in that position." (Peter – lines 273-276)

Nevertheless, there are positive glimpses of objection being respected and accommodated, but this is not always wholesale, universal or comprehensive,

"*Sharing the workload out. Yeah, like I say I've not really come across it a great deal, so people I've worked with as a team have put the position of the lady as uttermost." (Emma 161-162)*

In many ways, systems of conscientious objection accommodation are as informal as formal, as much about a shift in attitudes as introduction of draconian measures,

"*A supportive conversation – actually what ends up a tea-room conversation…'How do you see yourself? How would you declare yourself?' It's quite mainstream…but it wouldn't sit comfortably in break room chat." (Catherine 292-299)*

The taboos associated with CO make even more entrenched the debate.

6.6.2 Changing Job Descriptions

Again, there are suggestions that objections are being nullified unduly in submitting to service need. Contemporary challenges brought about by a burgeoning number of abortion cases has meant "*the job has just mushroomed*" says *Laura (20).* Generally, conscientious objection worsens the challenges of a stretched healthcare service. Data highlights deep-rooted cracks that may be multi-causal, admittedly, but which still create ever more chaotic working practices. Again, the pivotal lived experience is one of facing dilemmas – 'If not me, then who?' The demarcation of participatory roles is a source of Peter's frustration,

"I don't think you should defer responsibility to someone else, really, though we probably all do in different scenarios…That's what I mean about feeling cross. On those occasions where you're having to go to 3 or 4 different people to get the prescription of misoprostol, or whatever, because no-one wants to be the one who actually signs it. I think, 'Well all you've got to do is sign it! I'm the one who's actually going to be in the room doing it! Because I'm the end of the road here. If I don't do it – somebody else is

going to have to do it!' And I don't feel comfortable passing the buck to someone else constantly." (Peter 503-509)

Many departments heavily rely on bank and agency staffing - outsiders to the substantive team, segregated and with objections further unspoken,

"Not really understanding what the shift would entail, thinking it was more female/surgical nursing not really understanding the early pregnancy loss part of it… suddenly feeling....that that wasn't part of their make-up, or wasn't something that they subscribe to. At that point…it wasn't a requirement to make a declaration before the shift … that person saying, 'I don't feel I can care for that lady because… because I don't believe in this'...." (Catherine 36-43)

In the system designed to deal with unintended pregnancies, the cut off between gynaecological and maternity services appears to be a dubious equilibrium. CO is partly blamed,

"It's a bit messy really. I imagine if I was a Labour Ward Co-ordinator, that it would create some challenges potentially because you're having to ask people, on an ad hoc basis. I'm not aware that there is a register somewhere which lists all the people who have these objections, so, but may be there is." (Peter 56-59)

Alongside burgeoning bureaucracy, austerity has accentuated the difficulties,

"On a purely pragmatic level, I wouldn't want anybody who has made the decision to end a pregnancy for whatever reason and have that awkwardness when they're scrabbling around trying to find someone who can give them the care that they need. I have seen that happen, when you go to a doctor to do the prescription and they just refuse and then you've got to find another Doctor or bleep somebody else. That person is waiting, they've come in, and they're distressed, and the situation is made worse for them because the resources just aren't there for them to do what needs to be done." (Peter 80-86)

"There's more paperwork, though we've gone paperless! Erm, yeah, there's always a form that's needed and it keeps being added and added and added. I do feel the role has got bigger." (Nancy 153-157)

Advancing medical science combined with changing job descriptions signal developments in the role of the midwife. Anna states,

“You feel as if you are taking on more and more all the time. I mean, years ago we would never have cannulated or anything like that, would we?” (Anna 54-55)

Betsy struggles to forge autonomous practice forwards in her role,

“Because the profession’s changing, I don't think that we are particularly autonomous practitioners anymore. I do believe that we are obstetric nurses at the moment…. I do think I probably am being a little bit political here now, but I feel that we... I feel like the art of midwifery is in its demise, now. I think the way that we the way, that we work, and the constraints are within the NHS.” (Betsy 362-367)

This has implications for consent in CO because the emphasis is less on an assistive role to the doctor. As Emma states,

“Yeah, people know their rights these days. Whereas years ago, people just used to nod at the doctor, now they challenge the doctor.” (Emma 204-205)

Boundaries of advanced midwifery practice now may incorporate antenatal diagnostic testing, ultrasonography, medical prescribing, for instance, which all may have a bearing on participation in abortion,

“If the role is extended and extending, sometimes … it’s just, uh, a bit given that you can ...so all of a sudden, all midwives need to cannulate, you know, they didn't always have to in Matty when I trained. … Now every midwife I know cannulates. So, yeah, if it's on a small scale like that then it would be difficult to raise a conscientious objection too, if that makes sense. My level with bigger roles, I'm choosing to go along that pathway. And if I'm choosing it, I should be, and I should be open to what other things that brings with it.” (Betsy 276-284)

Betsy is suggesting that fewer CO opportunities exist with more responsibility. Elsewhere others like Catherine and Nancy suggest that for newly qualified midwives, CO is a novice lived experience. The dynamics of extended roles, means both between professions and within teams, the CO situation is still being metered out. Friction does sometimes appear. Laura experienced a disagreement dilemma in one referral she encountered in clinical practice,

“(The doctor) made it so she was very, very stressed. Because we’d set her up saying, ‘This is what will happen, you’ll go to the hospital, and they will sort out. Because although we didn’t do terminations at our hospital, we referred women … and we had

explained all this to her, 'So, you know? 'It's part of the process, go see the doctor, he'll sort out the paperwork'. And then when he didn't, she was ***devastated****. So, I actually did the referral myself because (### a private provider) take referrals off nurses and midwives anyway. So, I was able to do it for the lady. I just felt sad that she had enough on her plate and she was getting … (hesitates) getting resistance from people who I thought would help…….And the only thing, like you said, when you look we are supposed to provide individualised care and this lady, she couldn't handle anymore." (Laura 77-89)*

In the current regime, Maria describes how CO affects the team detrimentally. A lack of understanding and mistrust emerge as objectors are regarded as shirking or avoiding their responsibilities,

"The way everything affects the team: they'll be, like, 'They didn't want to do it because of this...they're just using this'…. I think the team naturally can be awkward. I don't think we are very supportive of each other. If there's work to be done…I think it would affect the team in the same way as everything does." (Maria 119-126)

6.6.3 Managing CO Since 1967

At key points in contacts with service-users along the abortion journey, Francesca thinks opportunities to participate are ongoing,

"That in itself is participation in abortion, even if at the end she decides that she wants to continue the pregnancy. She still needs someone there listening with an open ear so that she can have that honest conversation. So, I think it's right from the beginning, right up until the point at discharge." (Francesca 124-127)

In managing CO since 1967, approaches to accommodation have shifted, from one of intolerance to acceptance,

"I go back to 1987… at that point like I say, you were made aware that you could, um, object. You are also made aware that actually, that was not a great way forward - that actually these women needed your care, and you were almost withholding treatment. So, there was a recognition that you could. But as a midwife there was also, the…. assumption, or intimation, that you knew what you were signing up for so, basically, yes you can object, but what are you doing in the role, if that's how you feel …" (prosodic – nods at her own assertion) (Catherine 72-78)

Compliance with employers was the mainstay of policy, whereas contemporary objectors benefit from working environments in which rights are protected, vocalisation is promoted, and staff are supported by employers who have better realised the value of diversity and inclusivity.

"The management take on it was 'No. There was a higher calling than that – 'off you go' - and I would say that, nowadays, in this 21st century I think staff at all levels are now able to object and I think those objections are heard." (Catherine 89-91)

As bullying in the workplace is becoming more recognised, and its detrimental impact of smooth-running MDTs is being addressed, CO may come up as one more awkward sticking point at the heart of dysfunction,

"If I was to give an analogy, it will be like the midwifery bullying culture of the 80s. So, if you couldn't tolerate the bullying culture you left, and so, the bullying culture persisted. Nowadays that's all changed, but I would say that the students who are coming through, at the moment, would come up against an antiquated culture that needs, uh, a numbers' games to shift, and a tolerance to shift. So, individuals' sexuality in the workplace now is supported, recognised, and embraced." (Catherine 278-283)

According to Peter, a new departure begins in learning, thinking expansively and developing the right midwife to deliver the right care,

"Let's build more sociology and psychology into the midwifery curriculum. I think the new education standards are a bit better, but I feel we need to go a bit further, because that's where the potential is for change, in my mind. It's getting people to think through these challenges and processes – these are the leaders of the future! They will have to be dealing with all these policy changes." (Peter 531-536)

'Bottom up' solutions involve fostering the kind of environment which encourages practitioners to speak out, speak about, speak up and speak openly,

"I think that's why it's important you know it's, it's. It's. It's important that it's acknowledged…. it's important that it's acknowledged and not gonna end up an assumption, yeah." (Betsy 446-448)

"The management tool will always come back to - 'It's yours to declare, not ours to seek out'. So, we need to find ways of opening those as discussions. PMA's, to me, would be the way." (Catherine 348-349)

Karen talks of some of the existing infrastructure that could be applied to CO management,

"I think we are doing some good things in Maternity - discussing cases, live cases, that have actually happened.... could we have done anything better and involving service-users, in that table-abortion discussion. I think some of the investigations into what have gone well and what haven't gone so well, is where we are ahead in Maternity in some respects. We have external investigators that investigate things for us, setting a benchmark across the NHS." (Karen 306-310)

Once a system of conscientious objection is established, supporting objectors is just as crucial,

"I'd put it in a PMA-world. If the A-equip model is to do what it's supposed to do and keep us all in the workplace, then it sits nicely under their umbrella doesn't it? I don't think of it as a direct management tool. It is a management tool. But the management tool, will always come back to 'It's yours to declare, not ours to seek out'. So, we need to find ways of opening those as discussions. PMA's, to me, would be the way." (Catherine 346-350)

Finally, by addressing the kind of pressures that create CO crises, it is ensured that care is provided effectively without compromising patient safety or midwives' moral integrity,

"Just because you have a belief or an objection to that doesn't mean, make you any less of a caregiver, or a practitioner." (Betsy 112-114)

6.7 Findings Conclusion

We have looked at the evidence of midwives' ranging views, how these may merge and develop over time, depending on circumstance. The potential for a harmonious balance of rights has also been explored. Suggestions for alleviating moral distress associated with fulfilling professional obligations which may be incongruent with personal beliefs have been explored. The unanimous verdict is that supporting midwives, supporting service-users is the best way forward for a healthy health system. Where rights cannot be reconciled, an open, robust, transparent, and endorsed system of conscientious objection accommodation is just as valid, a supportive way of working to achieve the right midwife, delivering the right care.

Midwives' understanding and their interpretation of the legal provisos of the Abortion Act have been addressed. Although wholly supportive of the premise of the four criteria of the Abortion Act and mostly satisfied in the legal protection afforded to practitioners, some midwives were not aware of the conscience clause, notwithstanding. Lack of orientation on workplace rights mean that freedom of conscience is being expressed in a variety of ways, often subliminally. Because of a lack of policy, CO management is often inconsistently applied.

Many midwives hark back to pre-1967 conditions, which predict apocalyptic projections for public safety if a legally endorsed, accessible and free abortion service is not seen to be part of healthcare. This overrides any so-called 'repugnance' midwives may feel. Midwives' reaction to denying or withholding treatment in emergencies is one of abhorrence. Hypothesising what if? - if not me, then who? - is not without consideration of flaws in the current system and limitations in the scope of CO. Despite waning religious influences, traces of ancient thinking in questions around when life starts, potentiality and the idea of personhood preside. The fact that so many midwives comment in a derogatory way on how abortion is widely perceived as a "form of contraception" reiterates the moral, philosophical and theological gravitas with which CO dilemmas are treated. Nevertheless, feminist sentiment over women's rights abound, and midwives endorse patient-centredness and empowerment. Without exception, Humanitarian concern, and a desire to alleviate the distress of unwanted pregnancy does not entirely disregard consideration for the status of the fetus. In recognising the vulnerability of abortion service-users, midwives often express reticence about the detrimental impact CO potentially may have on care. Caution is based on reservations over accessibility, coverage, and equitable provision true to values of the NHS constitution. Affecting reproductive rights need not be, of course, a hindrance or inconvenience, if guidance is appropriately followed and CO is regulated, but there are gaps that call for redress.

That is not to say that without exception, midwives necessarily wish to partake in abortion. Despite predominantly pro-choice views, many have limited professional experience of participation. Some, like Betsy, would not consider applying for a post in an abortion providing organisation. Most talk of when they would conscientiously object in practice but have so far not acted on those beliefs. The important take-away message seems to be that midwives know their rights and what to do, where to go and with whom to discuss should they wish to express their freedoms. Reluctance to partake in procedures is mainly based on concerns over the medical/social justification of the

abortion, gestational viability and resuscitation-dilemmas, the parameters of which are adjusting all the time. Whilst contemporary midwives are mainly tolerant of objecting colleagues, this is still a tense relationship 'Yes, I support abortion for the women, but for me, I have different expectations for myself' appears to be the ultimate acid test.

It is acknowledged that achieving accommodation may yet require logistical juggling, a political rethink, a shift in the balance of power and dramatic change in organisational procedures. Rejuvenating attitudes which make discussion on CO more open, transparent, and accepted is also a pre-requisite to ensure that CO is no longer an assumption or a taboo. CO, ideally supported as part of a package of autonomous rights for the midwife as much as bodily autonomy for the abortion-seeker, urges a harmonious balance. Review of potential options for achieving this elusive goal will now follow in the discussion chapter.

Chapter 7 - Discussion

7.0.1 Introduction

The discussion chapter focuses on areas of convergence and divergence with theorists reviewed in the literature. In accordance with Smith, Flowers and Larkin's model, this section expands on findings, correspondingly organised in six elicited themes: 1) Practising Midwife, Practising Religion; 2) Navigating with a Moral Compass; 3) Fearing Reviving, Surviving and Thriving; 4) Being Torn Between Wearing Two Hats; 5) Two Signatures and the Escape Clause; 6) The Right Midwife Delivering the Right Care.

This chapter covers an examination of how midwives morally reason in a framework which is aimed to structure midwives' decision-making: in a "messy" process as data suggests they do. For example, the framework draws in part on the Consequentialist theory featured in the literature review, to demonstrate the 'what if' component in midwives' moral reasoning.The thesis asks what kinds of difficulties are being experienced and how might midwives be assisted in future: by standardising practice to become more transparent and consistent. Often suppressing their own objections in practice in favour of patient-centredness, midwives appear to morally reason that the choice and thereby responsibility for the abortion decision is off-loaded, falling in the realm of the service-user.

Finally, the chapter concludes with the explanation of a 'Model of CO Definition' – which highlights how ubiquitous and contested definitions relate to the conceptualisation of participation. Discussion also outlines participants' views, presented as a spectrum: a continuum popularised by Fink et al. (2016). Discussion here recalls how Fink et al. segregate objection into categories, from partial to extreme – providing much called for operationalisation of participation as a kind of pro rata procedure.

7.0.2 The Concept of CO Crises

The concept of 'CO crises' appears interwoven throughout. These ethical intricacies may not necessarily coincide with obstetric emergencies at the cusp of life, yet represent conscience dilemmas which often, but not necessarily, occur in conjunction with clinical dilemmas. In the unpredictable dynamics of midwifery practice, these dilemmas are accentuated, compounding the scope (and limitations) of what midwives do (Dickens 2000) and what they are expected to do. It may be helpful to distinguish here between a duty, responsibility and limitation. The extension in role leaves many midwives feeling caught in the middle, an impasse between employing organisations and those whose

needs are being served, morally reasoning and traversing dilemmas at key points in the abortion journey. A CO crisis differs from an ethical dilemma in that it relates to the circumstances, situations or scenarios in which dilemmas occur, are internalised, or morally reasoned by the individual. Whilst not all midwives profess a faith for whom their personal religious beliefs pose a considerable problem, participants do provide direct insight into the challenges of being a 'practising midwife, practising religion' (for themselves or others). Some of the ideas expressed in the Glossary (see Appendix 15) are reflected in the theme 'Practising Midwife, Practising Religion'.

7.1 Theme 1 - Practising Midwife, Practising Religion

Given the nature of mortal life and death, in health, there are many links to religion particularly in Maternity. Pastoral care, multi-faith prayer rooms, Sunday services, blessings, and name-giving ceremonies for the newborn (including stillbirths) and the regular attendance of hospital Chaplains show that in British society, the expression of religiosity is still outwardly a part of cultural norms and inwardly, behaviours. Without exception, all participants mention religion as a contributory factor influencing moral decision-making around conscientious objection and suggest that the religious institution's teaching impacts health-providers' behaviours because of their faith.

'Practising Midwife, Practising Religion' gives a sense of one philosophy spilling into another: a breach between church, (or Mosque or synagogue) and hospital. It represents a combination of the deontological and the diagnostic. Just as other observant participants confess their faith, for example, Jane draws on theological assumptions in her moral reasoning around freedom of conscience. In Jane's comments, the directive nature of pulpit sermons replicates a doctor's consultation. She highlights in the past the priest's role may be one of moral guide and champion. The Priest asserts the right to life beyond healthcare advice and their bombastic rhetoric brings with it moral judgment to a medical procedure. In the face of the orotund oratory, Jane's symbolic reaction is almost like a vote, or a protest. She mimics putting up her hand as if a child in class to a teacher, or in an act of defiant solidarity,

"When the Priest has damned and, you know? I've wanted to put m'hand up and say, 'Wait a minute!'" (Jane 118-120).

Jane's opening statements reveal how instructive religious teaching can be, yet also how Paternalistic this makes religious advice on abortion, especially if reinforced by the doctor. She appears later to endorse the beneficent support the church once offered

service-users, and the care, but suggests that belief may contribute to dilemmas. "*The point of idealism" (Jane 213)* presumably alludes to the kind of Absolutist ideology, which Jane hopes here to distance herself from. Moral culpability, therefore, rests with whatever is perceived as God, as if handing over responsibility exonerates the individual practitioner. The idea of weighing one's own complicity is a concept examined by Minerva (2017) whose article analyses the problem of viewing a medical procedure as complicit in wrongdoing - in the case of healthcare practitioners (and in particular Roman Catholic ones) who refuse to perform abortions for God given reasons, but who are nonetheless required to facilitate abortions by informing their patients about this option and by referring them to a willing colleague. Minerva (2017: 109) states,

"Although this solution is widely supported in the literature and is also widely represented in much legislation, the argument here is that it fails to both (1) safeguard the well-being of the patients, and (2) protect the moral integrity of healthcare practitioners."

In a more seasoned and accepting view of the balance of power in society, and ratio of objectors: non-objectors in healthcare, Minerva indicates there is still a place for recognising medics and religious practice in that. The greater share of service-users themselves in decision-making (born of expanding education and *"being more informed" (Jane 218))* seems to link feminisim with the realisation of sexual and reproductive rights with waning religious influence, on the other hand.

For some healthcare professionals, this sense of duty is realised in their choice of a Humanitarian career (Bruce 2018) and many participants, defend the sanctity of life. Midwives do not have to necessarily deal with the sick, however. Pregnancy is not a disease, but a transient, physiological state and pregnant service-users do not necessarily need a doctor (until that is, the pregnancy is unwanted, unintended, or unsustainable and abortion is indicated). This perspective perhaps justifies why conscientious objection poses a dilemma unique to midwives, whose normal routine is in nurturing pregnancy. Alleviating suffering in a noble, fervent way is widely seen as an extension of deontological ethics. For certain individuals, it may be a moral motivation which attracted them to becoming healthcare professionals. Helping her friend through pregnancy loss inspired Maria's career, for example. Maria's "*belief that life is sacred. I still believe that life is sacred" (Maria 239)* shows how her religious upbringing remains a key component of her midwifery ethos. This is the crux of Maria's message, above all: that the care she provides is in compassion, kindness, charity. These values are upheld

by many of participants, Karen (314-316) says, *“She’ll want somebody who’s kind and compassionate looking after her.... irrespective of what their views are, they should be kind and considerate”.* You don’t have to be religious to display this demeanour, value life religiously or maintain these perennial attributes, but saintly qualities are reinforced by scriptural teachings.

Generally, participants invoke rules-based ethics – the most obvious set of rules is the Ten Commandments, they imply - but participants fall short of handing over ultimate authority to an omnipotent and omniscient higher power. Like Jane, they question the church’s jurisdiction and traditional deontological philosophy about the ’gift’ of life. Instead, the focus is on self-determination and a moral right to realise autonomy, a right to life that finds voice in human rights charters. Despite recognising religion’s location within communities, professional’s veer away from committing themselves to a concrete ideology for their own part “*Catholic (and all the rest that goes with it)” (Gillian 43)* – they are also cautious about *‘playing god’ (Peter, Maria).* A third-party view is recurrently obscured, dilemmas are more about the service-users’ relationship with her offspring and the practitioners’ interference in that. Service-users’ own accountability is given more weight in terms of moral culpability and the practitioner’s role is superseded, the woman’s choice being paramount. Fox (2012) describes the origins of ‘the gift of care’ as a predominantly Christian concept, derived from the Latin word ‘caritas’ meaning love, charity, and compassion (Fox 2012: 167). The ideas of caritas find expression in many of the following traditional religious dictums, including ‘Thou Shalt Not Kill’.

7.1.1 Thou Shalt Not Kill

‘Thou shalt not kill’ – a direct quote from Ivy (151), draws on the sixth of the ten commandments (Exodus 20: 1-17; Deuteronomy 5: 6-21). In the New Testament, Jesus summarised righteousness into two great principles: love of God and love of neighbour. The dilemma for a practising midwife, practising religion is that these may be in conflict. Maria (236-237) tells us,

”*There was a lot of input in families from the church and the belief that life is sacred (I still believe that life is sacred),”*

which is testimony to the continuing relevance of the enduring concept of human dignity in her moral reasoning. The concept of human dignity is another thing that a divine being gives to humankind. In RC social teaching, the phrase “Human Dignity” is used specifically to support the belief that every human life is sacred. This defines the

denomination's dedication to social issues like ending the death penalty as well as justifying the church's position on abortion. Thus, recognising human dignity and the universality of human rights are inextricably linked with respect for persons.

Catherine's comments demonstrate traceable links between religion and conscientious objection. There remain underlying theological and philosophical reflections which impact on her colleague's delivery of care relating to the fundamental principle. The concept of human dignity is reflected in her commentary on conscientious objection – the lived experience of the nurse's "*disagreement was with ending a life." (Catherine 67)* summing up the sentiment of 'Thou shalt not kill' and the primacy of God's will, above that of man. Healthcare practitioners are often motivated by humanitarian concern, aimed at alleviating distress and preserving life (Bruce 2018 covers this), values that for this nurse seem to be contradicted. Making sense and giving that life meaning rely heavily on beliefs about whether a fetus constitutes an embodied human and whether it represents independent life. The pertinent moral question raised, says Catherine was not *"the suggested morals of the woman.*" Here it goes deeper than casting aspersions. Maria elsewhere quotes the biblical teachings of Jesus on the nature of criticism and accusation (as He is attributed in John 8:7, 'Let ye who is without sin, cast the first stone'). This indicates some residue of a Kantian Christian philosophy ('doing unto others', the 'Categorical Imperative'). Applying Kant assumes that there are universal rights – no-one greater than another – and that the fetus is included legitimately as an 'other'. The verse in the Bible, "Do unto others as you would have them do unto you" is commonly known as The Golden Rule. It is found in both Matthew 7:12 and Luke 6:31. Jesus said this Golden Rule sums up the Law and the Prophets as a rule to live by. As well as theological and philosophical, there are professional traits of an ethos encapsulated in the Hippocratic oath (in which practitioners vow to preserve life). Catherine reflects on what she feels is the issue which could contradict some people's values and beliefs in three regards – theological, philosophical, and professional. Catherine suggests the nurse's focus is more on the protection of 'the innocent' fetus and life's sanctity which implies the conflict is internal, fundamental to her beliefs, rather than a comment on the nurse's mistreatment of or disengagement from her patients as a misconduct matter, because of her religious affiliation.

Perhaps for the nurse, her religious motivation embodies the sacraments celebrated in the Christian faith which include anointing of the Sick. These are widely taken to represent a religious rite, in service of God, through which we share belief in Him in our life. Thus, acts of compassion may constitute a part of ethical decision-making, for

believers, by incorporating Jesus' example. At various points in the Bible, Jesus' role is portrayed as that of a healer. Reviving a Gentile Centurion's servant (Luke 7: 1-10) and curing a leper (Luke 5: 12-16) are examples of the value attributed in faith to the sanctity of life. The story of benevolence, even though towards Pagans in both of these scriptural accounts, shows the importance instilled in being kind to those whose beliefs one does not necessarily agree with and the virtuous nature of conscience beyond religion.

The embodiment of the church's teaching is based on the inviolability of life as sentient, sacred and holy. A look at freedom of conscience as a spiritual matter expresses the primary virtue-based ethic: do no harm, the measure of this non-maleficent principle here is that it extends to the fetus.

Although her moral reasoning relating to her abortion standpoint has become more mellowed with time, from one more compliant and conformist to one invoking autonomy, Maria rationalises arguments by Christian ethics. Even so, the idea of the fetus being *"a baby (is) housed in somebody else's body, and they've got the right to make decisions about what happens" (Maria 334-335)* is an interesting residency notion in contradiction of this. The choice of term is also a paradoxical one, more in keeping with Judith Jarvis-Thomson's (1971) feminist approach. Like Maria who disregards paternity rights *(383-384)*, Jarvis-Thomson discounted third party involvement, raising questions about bodily propriety – to whom does the fetus belong? The violinist's dilemma was one of inter-dependency centring on rights: to temporary tenancy rather than an accommodation in a house, a 'House of God' perhaps. Ultimately, what Maria recognises as 'pivotal' is the idea of reproductive justice, realising rights to self-determination above and beyond the dictates of the church. In moving linguistics of 'you' to 'we' she calls on a common identity, making sense and meaning from her solidarity with the body with the Christian church to which she belongs, womanhood and humankind. She is just as much a member of the society in which she practices, so she agrees universal rights should not be disregarded.

Canten's (2007) work on duty strikes a chord here as an obligation, for midwives, a duty to care (see section 2.7.0). Contrasts Cantens makes between absolute and 'prima facie' duty remind us that not all beneficent duties are clear cut in every circumstance. For midwives, dealing with two lives, in sexual and reproductive health, there is conflict and participants agree.

"Understanding because it is about a life. But, two – there are repercussions and consequences of every decision." (Jane 129-131)

Decisions may depend on the situation and reasoning here relates to predictions, weighing up and balancing the good versus bad outcomes, very much a feature of ethical Consequentialism. A facilitatory approach to reproductive justice supports this, places the onus on the service-user. It is the service-user who holds the main responsibility for the abortion decision and who bears the consequences of that decision. So Maria chooses against abortion for herself. Maria's assumption (that "*obviously I do believe everyone has the right and choice"),* is an affirmation that she has convictions which are to her are *"obvious"* (presumably by the demonstrable choice of women's health) in her non-objecting status. She has resolved the dichotomy. Her personal views may have originated in her religious upbringing yet stemmed, branched, metamorphosing Maria to the midwife she has become with career choices she has realised.

That life is ordained by god, in the belief "*It is written"* commits *"a grey area" (Peter, Karen, Gillian)* like moral reasoning to intractable black and white. It is a duty, a commitment declared weekly at church services, 'Go in peace to live and work to His praise and glory' – an affirmation that shows deeply ingrained attitudes can spill out into everyday life.

7.1.2 Reinforcing Attitudes to Procreation

In Christianity, Islam, and Judaism, it is because humans are said to be created in the 'image of god', becoming 'children of god', that reproductive health, fertility and procreation are perhaps so pivotal to religion. Procreation features as part of the creation story and many of the participants (Peter, Gillian) discuss when and how life starts from a religious perspective. In Genesis 2:7, with symbolic imagery, it is stated,

"The Lord God formed the man of dust from the ground and breathed into his nostrils the breath of life, and the man became a living creature."

Adam and Eve were created by God and blessed with a God-given capacity to reproduce popular Christian tradition maintains. In fact, in Hebrew, 'Eve' means 'life' or 'living'. Eve was our very first mother and all the world must come through her line and manner of birth (not creation), the doctrine upholds. In Genesis 1: 28, God creates the world then blesses humanity,

"God said unto them, be fruitful, and multiply, and replenish the earth, and subdue it: and have dominion over the fish of the sea, and over the fowl of the air, and over every living thing that moveth upon the earth."

It is precisely because of this creed encouraged in the Bible that the 'gift of life' becomes so significant a dogma, making the interruption of procreation unacceptable to some believers.

Hannah's recurrent references to strong Islamic beliefs that "*It is written"* demonstrate that conscientious objection is not exclusively confined to Christianity, *"Religious reasons, well, they've just got their own views.... that they probably may be well against it. That they believe abortion should not be allowed." (Hannah 69).* In Islamic moral reasoning around the sanctity of life, according to Hannah's account, the fate of the fetus is pre-determined by a higher being. Dealing with Muslim patients, the philosophy is similar,

"In her head she kept saying, yeah, but it might be fine. They don't. They don't know what they're talking about. It could be fine, and I kept thinking they've had serial scans it's not gonna live, but…It's what they believed in, and I remember them saying, 'You know, we're not going to provide any care on the neonatal unit'…just let it pass away." (Hannah 630-634).

Hannah's experience of maternal mortality fosters in her a dread, a sense of duty and commitment to the constitutional values of the NHS. The premise - if not me, then who will care for this woman? features strongly. Lessons learned from history are reinforced with the sense of danger, *"If … somebody bled like anything - how would it really end?" (Hannah 61-65).* She reiterates her professional values emphatically "*(A trip down memory lane) ...that's what will happen if it is stopped by the NHS!"* she warns.

Under *Sharia* abortion reflects both the religious laws and the moral code of Islam. *Hannah (37) states, "They're not allowed to take part in abortions - as being a Muslim".* There are two primary sources of *Sharia* law, the first one is the precepts which have been set through the Quran and the second one stems from the examples which have been set by Muhammad, the Islamic prophet under *Sunnah,* according to Naden (2007), cited in Almutairi (2007). The applicability of *Sharia* is interpreted and expressed through *fiqh*, that is, Islamic jurisprudence. The reasoning and thoughts under this law are quite different from the ones under the Catholic reasoning, Almutairi (2007) states. This is because under *Sharia* law, the reasoning is taken from the Quran or from the *Sunnah*, instead of taking the same from the general principle with regards to a particular condition. The understanding and the spirit under the Quran or Sunnah are applied to the situation and for its reasoning according to Bailey (2012), cited in Almutairi (2007). According to Standke (2008) cited in Almutairi (2007) "It is basically the law of God."

7.1.3 Let Her Without Sin Cast the First Stone

"There's a lot of room for us to judge and in any situation, lots of room to make a judgement that's not your judgement to make. A bit like, if you are religious, 'Let those without sin, cast the first stone!'" remarks Maria (324-325), sense and meaning making about midwifery practice with a Christian lexicon. Maria uses an everyday phrase originating in biblical teaching to best effect, making deep theological, moral reasoning understandable to contemporaries. In doing so, she reiterates ethical principles of equity and justice whilst cautioning practitioners about blame and finger-pointing in the same way that Jesus is cited as doing. In biblical gospels (John 8:7), Jesus teaches lessons on fairness, implying no-one is faultless or has such a right to pass judgment.

Figure 13: The Blessed at the Gate to Heaven with St. Peter (1467-1471) by Hans Memling

Ivy's comments on God *"looking at the wider picture"* remind us of the adage that on judgment day, Christian believers are called to justify the conduct of one's life to God, a rich, metaphorical reiteration of Christian moral reasoning and ethical-decision-making. It is inspired by the description of the New Jerusalem in Revelation 21:21: "The twelve gates were twelve pearls; each gate being made from a single pearl." The image of the gates in popular culture is a set of large gold, white or wrought-iron gates in the clouds, guarded by Saint Peter (the keeper of the "keys to the kingdom"). Those not fit to enter heaven are denied entrance at the gates and descend into Hell. In some versions of this imagery, Peter looks up the deceased's name in a book, before opening the gate. Whether determined to be good or bad, the tradition dictates one's fate for all eternity – to be spent burning in purgatory in Hell's inferno or heralded a rather more celestial welcome by Heaven's angels. The thought of being reviewed for the actions of one's life strikes a chord with other less Saintly forums in which a practitioner may be held accountable by public officials.

Although a 2016 letter by Pope Francis, the 'Misericardia et misera' (Mercy with misery), gave Priests the ability to grant forgiveness for abortion-related sins, resulting ex-communication does not appear in data. Prior to this, permission was reserved for

Bishops. According to Canon law, the church traditionally supports the idea that life begins at conception – the point at which the ovum is fertilized by sperm – and therefore abortion is a cardinal sin. The edict by Pope Francis announced a new departure: that there is no sin that God's mercy cannot reach and wipe away if a repentant seeks reconciliation (Cleveland 2019). There is no mention on ex-communication in the data, but one could surmise that for believers, what constitutes a cardinal sin could impact on moral reasoning. We are all only human, we can make mistakes, is more the gracious line taken in the data. One example of this is how forgiveness is discussed in the tone of Ivy's comments. Others take an alternative view: one of 'conscientious provision' (Dickens and Cook, 2000; 2011; Parker, 2017). This resonates with Parker's (2016) argument that a religiously informed conscience can motivate care in favour of supporting care for women seeking abortion, rather than urge abstention. This is the argument that Ivy seems to be supporting here, *"Somebody said, (and I do believe this) that, 'my God wouldn't judge you for supporting somebody' (Ivy 79-80).* In sense and meaning making the lived experience of ethical dilemmas, for Ivy, she is exempt from being judged by any higher power, as is the woman, because God is deemed to be all forgiving.

The idea of atonement of sin, penance and forgiveness converging with ethical principles are reflected elsewhere in decision-making. Gillian's *"say a few Hail Marys"* data (440-447) converges on this point, for example, when she ensures that whatever health-providing actions are sanctioned, above all, they should do no harm, and promote non-discrimination. Gillian's is a very rights-based approach in this.

Whilst a range of factors can inform care decisions, (religious and moral beliefs are traditionally expected), professional beliefs about moral obligations to patients, political views regarding women's reproductive rights, and personal experiences can also influence the decision (Czarnecki et al. 2019). Data supports this. Jane ponders, *"I suppose we are all products of what we have experienced in our lifetime, erm…" (Jane 31-32).* The semantic emotional element, walking a mile in somebody else's shoes, yet separating feelings from professional judgment is key in her sympathetic attitude, *"I suppose it's down to an individual as well, on their character and whether they can compartmentalise a professional persona away from a personal persona." (Jane 33-34)*

Peter suggests having a faith answers a lot of these ethical questions,

"Yes, so I imagine if you have strong convictions or religious beliefs that that would seem a bit more clear cut. But maybe your own personal experience of...having made a

personal choice and having to decide which side you came down on, might affect your experience as well." (Peter 96-100)

Christian ethicists suggest this discernment is also a journey, a kind of developmental or evolving mechanism for ethical decision-making, riddled with self doubt and only becoming surer with reflection and self-questioning. This is where the framework of moral reasoning may equip practitioners,

"From willing the good, to knowing the good, from knowing the good to doing the good." (Wogaman 2009: **xv**)

Arendt (1929) saw conscience as essentially 'a fellow traveller to man and the evidence of God on Earth'. Her Doctoral thesis on Saint Augustine drew on Socrates teaching, arguing the ontology that no-one can do evil voluntarily. Socratic questioing was first mentioned in section 2.1.0, which mentioned three Socratic paradoxes. They are: first, that no man desires evil, all men desire the good; second, that no man who (knows or) believes that an action is evil does it willingly. On the contrary, all the actions that a man does willingly, he does with a view to achieving some good; and third, that it is better to suffer injustice at the hands of others than to do unjust acts oneself. Although through this type of introspective bargaining, dilemma-analysis may be conscience-driven, rather than solely religiously motivated, Arendt attributed conscience to the presence of God and our reliance on him points to the Creator (Vetlesen 2001).

Whilst all participants do know about the theological origins of conseeintious objection, some are adamant in explaining their conviction that it can also be conscience-based, in accordance with moral beliefs or on principle. It is almost as if to distance themselves from the illogical or unreasonable to present themselves in a more considered way. Practising midwives, practising religion are no more morally right by the nature of their faith, it is deemed. Believing in fetal rights to life does not depend on practising religion or being a midwife, participants assert. For those participants who do not uphold a religious doctrine, of any denomination, objection may still pose dilemmas. In traversing that very personal journey, to guide themselves through the dilemmas, navigation may be with a *moral* compass.

7.2 Theme 2 - Navigating with a Moral Compass

Most participants see their signposting as supportive: a share in the decision-making rather than advisory or instructive. It is a more facilitator role, one which communicates

options, a less Paternalistic kind of gatekeeping than traditionally assumed in medicine and the church. The thrust of the thesis is that rights to freedom of thought, conscience and expression are mutually and universally recognised. One person cannot tell another what to do or how to act. Recognising the limits of one's professional role and handing over that decision-making capacity is what empowerment is all about. This is very much bound with equity and autonomy, as Peter's comments seem to suggest. His warning against any selectiveness seems to suggest Peter considers all midwives to have options, along a career pathway (what Francesca (20-21) terms *"avenues of maternity")* but it is Gillian who picks up on this metaphorically as a *"moral compass*". In likening conscientious objection to other objectionable cases in caring, such as Jehovah's witnesses and anti-vaxxers, Gillian highlights there are 'Thought and Moral Processes' that midwives work through, common to all ethical dilemmas. These are epitomised in the framework of moral reasoning (see table 8), intended as a reflective tool, a point of reference for practitioners when they may feel lost or in need of guidance, whatever the scenario. In practice, exercising choices in freedom of conscience pits health care professional against service-user, fellow professionals, employers, and sometimes even governments. The consensus is that disagreement within the multi-disciplinary team benefits no-one and much worse, detracts from therapeutic relations. In carrying out the instruction of the doctors, in accordance with outlines in 'The Code', there are *"still quite ethical"* situations to face in the strife. Focus is on whether professionals act beneficently here and alleviate suffering. Comments reiterate the gravitas of the abortion decision, mirrored by practitioners. How to balance the right to a service with the right to abstain from providing that service appears to be the main dilemma, the issue of conscience.

7.2.1 An Issue of Conscience

We have looked at the relevance of conscience to healthcare, (Lamb et al. 2016; 2019; Savulescu 2001; Giubilini 2014) and indeed to the internal health of practitioners (Wicclair 2011; Brock 2008; Birchley 2012; Arendt 1978). Like Catherine, Betsy appears to be referring to outward demonstration, religiosity, and observance as a guage of strength of conviction, yet she also acknowledges the unconscious "*inner self*", a characteristically unique and true nature of conscience. Her emphasis on wider learning, growth, and development outside of formal education and professional experience is perhaps one area of convergence with other participants. Like Diane, conscientious objection as an aspect of moral development is learned as much culturally, Betsy implies. Becoming mellowed with exposure to women's issues, Diane voices moving from compliant to less conformist views, invoking free will. What Diane recognises as

‘pivotal’ is choice. It relates to the idea of reproductive justice, realising rights to self-determination above beyond the dictates of the church.

Peter’s analogy, which opens the theme ‘An issue for conscience’ perhaps refers to the selectiveness of decision-making. The phrase “*pick and choose (the) bits that suit us” (167)* conjures up imagery of pondering in a metaphorical confectionary shop. The point being, here, that the practitioner does not accrue the same consumerist rights as service-users. Peter appears to be making the bold ethical assertion that nor should they. Theorists like Savulescu (2006; Savulescu and Giubilini 2018), whose position maintains patients should not be left like customers, shopping for care, could be said to be similar to Peter’s. If clinicians are unwilling to provide care because of a conflict with their personal values, 'they should not be healthcare professionals’, a sentiment expressed often in the data (for example, by Jane and Anna). Schuklenk and Smalling's (2017) primary concern is that patients obtain the care they need, and they believe conscientious objection potentially disrupts this. Others maintain that anti-objection views neglect that most of legal reasoning is contextual and that the blanket restriction of healthcare professionals' freedom of conscience is disproportionate (Maclure and Dumont 2017). Glick and Jotkowitz (2017) warn of the serious, yet largely unsubstantiated, harmful effects on the ethos of medicine and of bioethics if professionals are not afforded freedom of conscience rights.

The analogies Gillian makes to breastfeeding, anti-vaxxers and Jehovah’s Witnesses support her broad position: namely that accommodation of choice is something to be fostered - but with limitations if there are implications for others. There are traces of Relativist ethical thinking in her dialogue, *“Uhm, depends on what it is, maybe something emergency or otherwise,” (Gillian 134)* demonstrating how conscientious objection may be circumstantial, interpretative, and ultimately individualistic. Although respect for persons may take precedence as a guiding principle, it is still subservient to autonomous rights to self-determination. Linked to duty of care, Gillian notes the commitment and obligation of the professional to “*fix everything and make sure everything is OK” (137).* That there remains still disagreement compounds the dilemma too. Crucially that someone else’s views may be different but that objections are non-negotiable makes them no less easy to accept. Gillian seems to be implying here that to try to dissuade an objector from their position is unethical in itself, overbearing and paternalistic. The literature review covered how paternalism restricts self determination, denies equity and implies one person’s authority is somehow greater than another’s. Recognising autonomy is the gold standard for invoking coercion-free care, therefore. It

has been stated, in manipulating freedoms, paternalism violates moral rules but more so practically, is open to control, and interference (Andre and Velasquez 1991). None of Pecorini's (2002) conditions for acceptable paternalism seem to apply here. Indeed, whilst participants are mindful of the harm principle (to stop harm caused to others), their main concern is that harm caused is iatrogenic - at the hands of the care-provider. Relinquishing autonomy could *"grow horns*", Gillian warns.

Anna's approach is very much situational and in exercising conscience, she reserves judgment on others. In Anna's words, moral reasoning can be pragmatic and "*depend on the scenario". (88-89).* This is where many midwives invoke case-by-case justifications. Rationalising the woman's cited reasons can be problematic (*"growing horns"* proffers *Gillian (207)*. Like most participants, for Anna, the frequency of termination for non-medical reasons, "*doesn't sit comfortably", (Anna 121-126)* and this above all else, poses a CO crisis - an issue for conscience to unravel, decipher, decode and lead the way from confusion. When thinking about the cryptic nature of these thought and moral processes, a framework has been devised, which features shortly, in table 8.

7.2.2 Thought and Moral Processes

What route to take home? Where to have tea? Whether to go to work? Which cinema film to watch? all represent everyday choices in circumstances in which incentives versus burdens are balanced. In terms of key stakeholders, we regularly ask ourselves, who are the winners and losers? Does this act serve my needs or is it a requirement from some other beneficiary? Morals help explain if those simple decisions are right or wrong (Hewson 2001). The 'Framework of Moral Reasoning' (see Table 8) formalises these thought and moral processes about the questions posed, internalised and mulled over.

What the eye doesn't see, the heart doesn't feel.
Traditional saying

In Hermeneutics, the importance of capturing a camera snapshot of the phenomenon 'in being, time and place' can never be underestimated. Peter's quote is a fine example of that existentialism, posturing the midwife to the delivery room, who *"kind of eyeballs the person" (381)* faced with a CO crisis. Thus, the reader is reminded of Peter's lived experience of participation and why conscience matters matter for midwives, being most at hand, in terms of the impact they face. What Peter calls here,

professionals *"bringing about an end to this life" (213),* Betsy elsewhere refers to as those "*doing the do" (424).*

The thesis will add to Ben-Moshe's (2019) theory by answering questions about which conscientious objections are justified, genuine (in accordance with Rawl's 'reasonableness' criteria) or complicit. It will show how midwives move from fears of accusations of being an accessory to the act (known legally as double jeopardy) to key player with recognised rights. 'How does one respect the practitioners' claim or conscience and protect patients' interests, without leaving practitioners complicit in perceived or actual wrong-doing?' asked Ben-Moshe.

Betsy suggests that taking account of everyone in the multi-disciplinary team may go some way in ensuring accessibility, yet without complicity. If midwives were used as second signatories, as Peter suggests, there is a greater pool to draw upon, especially in social abortions, when the justification relies on insight into lifestyle that medics simply don't generally focus on. Betsy emphasises the scant regard paid in the literature to midwives, as a professional group amongst others. *"I am not dissing my medical colleagues…They come at it from a very different angle." (Betsy 415-419)*

To address these dilemmas, one of the mainstays of accommodation is the 'duty to refer', which Dickens (2021: 556) states,

"Governs care that practitioners cannot, or will not, provide. Conscientiously objecting practitioners bear ethical and legal duties not summarily or arbitrarily to terminate their responsibilities for their patient's therapy or appropriate care, under sanctions of abandonment."

This represents a logic, which Hannah suggests is fairly straightforward,

"Other doctors should be able to refer them on straight away…. I don't see why they wouldn't refer them" (122-126).

Absolutists (by Wicclair's 2011 definition), however, would maintain any involvement in abortion renders the participant morally complicit (what Peter means by *"being part of this process" (214)*. How best to withdraw in the preliminary stages of the abortion journey, facilitating ease of access without hindrance, delay, inconvenience, or harm to the service-user remains a dilemma. Needs assessment and cost-benefit analysis may seem like jargon better suited to marketing or management speak but midwives' employ

similar techniques of “weighing up” conscientious objection pros and cons (Urmila 2007). It is then that a ‘moral compass’ may be employed, reflecting on pertinent, Socratic-type self-questions, which here are formalised in a framework.

Table 8: Framework ‘How Do Midwives Morally Reason?’

…..**by asking themselves**	…..**by asking others**
- Is it necessary?	- Is it legal?
- Is it safe?	- Is it a shared decision with colleagues?
- Is it right morally?	- Is there professional guidance?
- Is it ethically sound?	- Is it clinically evidence-based?
- Is it fair and justified?	- Is it supported by organisational policy?
- Is it something I have experienced before?	- Is it societally approved?
- Is there a repercussion or consequence of my action?	- Is it culturally sensitive?
- Is it against my principles?	- Is there a scriptural teaching on this?

The framework makes a distinction between the inner self (where decisions are conscience-based, internalised and highly personal) and the outer being (morality-driven, communal questions, to which answers may be societally constructed).

This two-step approach builds on others’ ideas – Sulmasy, Schulenberg, Velasquez and Adam Smith. Firstly, Sulmasy’s (2008) view of conscience, which distinguishes between retrospective/judicial conscience, (where judgment is passed that a wrong has been committed) and one which is prospective/legislative (anticipating wrongdoing). Section 2.8.8, which looked at ‘What is conscience and how it is different to moral reasoning?’ introduced the term synderesis and highlighted more moral elements of these thought processes. This framework draws specifically on that synderesis.

It builds on Schulenberg’s (2015) responses and Velasquez et al.’s (2015) five question approach. The ‘Framework of Moral Reasoning’ conceptualises the insight gleaned from data and applies theory. For example, in section 2.3.4, Schulenberg’s perspective on the role of moral imagination in making judgments by questioning, was examined. There it was asserted that self-command is key. What Dewey says about moral imagination: that creativity should be used to discern moral truths, unhinder a sense of morality in one’s own actions and avoid moral chaos ultimately finds voice in the framework – but with consistency. The Framework aims to show elements of self-reflection – by asking

themselves (as, say, Raphael (2007) suggests Adam Smith's 'Impartial Spectator may do, as 'man within the breast'). Application of the framework answers Sulmasy's criticism against an 'intuition-orientated' view of conscience because it is fallible.

The second part of the framework, 'asking others', is more judicial and societally motivated. There is no such thing as a "distinct mental faculty…a little voice whispering to us" to determine between right from wrong without advice or consultation (Sulmasy 2008: 136). This assumes that individual conscience actions are mutually approved and communally deemed to be acceptable, a Communitarian view of ethics expounded by Mackintosh (2014) that is inter-dependent and collective. For Mackintosh, relationships and membership in society are wholly important in a communal view that blurs the boundaries of inclusion. Taking it further, communitarian ethics also smudge the limits of individuality. This goes further to locate the decision when midwives may feel 'Mentally Traumatised'.

7.2.3 Mentally Traumatised

For midwives, the most critical point for a 'CO crisis' is the first contact, when in the thought and moral processes, the framework may initially have been employed, though its outcome is anything but set. In response to that initial dilemma, the outcome of the ethical decision, may set the trend, a blueprint on which the entire therapeutic relationship. It is clear from the data that for some midwives, moral distress is incurred in this process, being ethically "torn".

Peter's account of the booking interview clearly highlights that for an estimated 10% of clients coming into contact with Maternity services, pregnancy is not a wholly welcome diagnosis. For various reasons he recounts the sometimes unwantedness, unexpectedness or unintendedness of pregnancy. Emotional reactions - like upset, anxiety, distress - highlight what difficult decisions may lie ahead. Peter's signposting recites the midwife's role in providing available options, falling short of giving advice, in a professional way. Broaching the subject of abortion and making accessible legal services includes an even-handed, equitable, non-judgmental, and non-discriminatory approach. Reports of a 'cult'-like G.P. surgery where all staff are objectors, paints a very unfavourable and freakish picture of freedom of conscience. This is unusual for Peter, who elsewhere mentions dangers of using value-loaded terminology and displays a rather more metred and balanced linguistic style. Although his position on conscience is tempered with considerable caution, he is keen to stress that a belief that CO is not a solely religiously motivated notion. All in all, along the "messy" abortion journey,

reflecting on the vulnerability of service-users, especially those choosing abortion for social reasons – Peter highlights another source of CO crisis.

Realising freedom of conscience without infringing others' rights is the benchmark that many participants talk about. Exonerating oneself and the participation they look to the service-user to shoulder responsibility. "*Sometimes you deliver these babies, and they look a perfect thing, and you think, 'Oh my God! What have you done?' But it's like you say, it's not up to us" says Hannah (45-47)* relaying just how much midwives are impacted, *"mentally traumatised"* by the ethics of the situation (Betsy 412).

Affected practising midwives, practising religion by the theological concept of personhood (Mackintosh 2014) that invokes *imagio dei* ('In God's image' (Genesis 1:27), there is also human connection expressed here by Hannah and Peter which shows elements of the moral distress being navigated using a moral compass. It helps to recall Mackintosh's (2014) ideas around personhood here (which interpret personhood as biological, psychological, substantive, theological or experiential – see Table 3) and Savell (2007) who argues that new technologies, like 4D scans, associated with expanding medical science have brought about a greater connection with the growing fetus in common humanity. Delays which unduly compromise the patient exacerbate timing dilemmas. Added pressures make abortion (and freedom of conscience) decision-making more critical as gestation progresses and human life develops when the lived experience of ethical dilemmas becomes ever more real.

7.3 Theme 3 - Fearing Reviving, Surviving and Thriving

The central dilemma of how to achieve the best outcome for the pregnancy, realise choice and facilitate bodily autonomy balanced with fetal rights to life features the interdependency of two lives, impenetrably intertwined. Anna's contribution unravels the enigmas of what constitutes life and defines the debate. She highlights how gestational dilemmas recentre care.

"The age of viability is a big question, really, isn't it? As medical science advances, there are going to be younger and younger babies able to be looked after, born and survive, and, hopefully, thrive." (Anna 135-137).

This third GET links the dilemmas associated with differential diagnoses of congenital conditions ('Encountering a Diagnosis Minefield'), the age of viability (titled in the thesis

‘Medical Marvels at 22 weeks’) with considerations of potentiality (‘Living a Full, Full Life’),

7.3.1 Encountering a Diagnosis Minefield

Peter enlightens us how moral reasoning may be bound with differing perspectives on disability. Generally, in the data, abortion decisions based on anything other than life-limiting conditions are not evaluated well. Nancy, for example, heavily criticises performing procedures based on cleft lip and palate. In sharp contrast, Trisomy 21 is cited widely in the data as not a reason to abort. Midwives did not wholly sympathise with this more common diagnosis as a reason to abort. Despite these reservations, Peter however does not object, and goes along with the patients wishes to terminate *“ a pregnancy which they felt they could not support”.* He receives such positive feedback on his care that it makes a lasting impression which confirms his axiological position. When an onlooker, the moral reasoning starts and ends in a different way to when the situation is their own. Then, participants apply different principles. Maria is a prime candidate of this logic. She doesn’t object to somebody else realising their own choices, but she herself would not undergo the procedure. Likewise, for Karen, clarity is brought not by the testing itself, but by imagining “*what I would have done with my pregnancies, had an abnormality been picked up”.* Here, Karen’s moral reasoning is hypothetical, but she reflects on her actual lived experience of pregnancy, too. Societal approval apart, despite attempts *‘to try and sway you’, (263)* Karen’s ethical decision-making is reflective and determined.

This ‘changing face of pregnancy’ is also echoed by Karen, Laura, Ivy and Jane who provide us with extensive insight into screening, antenatal diagnostic testing and the Harmonie research trials (Betsy points to ultrasonography). Elsewhere, developments in fertility treatments, In Vitro Fertilisation (IVF) and assisted technologies are said to pose contemporary conscientious objection challenges (Schenker et al. 1997) not faced by 1967 counterparts (Betsy/Jane). Ivy’s comments reiterate the complexity of ethical decision-making for the practitioner in support of conscience-based refusals which can snowball to other specialities – like fetal medicine and fertility treatment. The metaphorical note in the example, relates to stereotypical Aryan “blue eyes”. Like Laura, who mentions her repugnant reaction to “*crusade(s) against them….to rid the world of any person with Down’s syndrome that didn’t deserve to be in the world along with the rest of us” (Laura 128-130),* participants do recall dilemmas through an anti-eugenics lens.

Eugenics is the study of how to arrange reproduction within a human population to increase the occurrence of heritable characteristics regarded as desirable. Developed by Sir Francis Galton as a method of improving the human race - eugenics was increasingly discredited as unscientific and racially biased during the twentieth century, especially as a Nazi doctrine in order to justify maltreatment of the Jewish population in 'The Final Solution', disabled people and other minority groups. What eugenics is NOT is a natural selection advocated by Darwen - a proponent of survival of the fittest and Malthus - who saw war or disease as a way of controlling population. It is reminiscent of the first medical objectors, who were Polish doctors opposed to the final solution. It reconfirms that planned breeding and racial improvement does not work. This is relevant because it reminds of why the UN Convention on human rights was created to establish common humanity, and the dangers of doctors playing God. In trying to emulate a higher power in determining between life and death in a daunting and light-hearted game of chance. In Peter's statement here, explosive, combative metaphors burst onto the reader's consciousness throughout, symbolic of Clarke's (2017) military analogy, in this way. Just as Peter talks atomically of *"pulling the trigger"*, they talk violently of *"blood on their hands" (494-495)*: stark imagery which invokes the passion of the debate. Cumulatively, these rich descriptions serve to demonstrate the degree of ethical battle, a minefield, as it were. The unanticipated nature of being faced with a moral dilemma at the start of his shift, drives home how tumultuous dilemmas can be in the moral imagination.

Despite her admission as an abortion defender, Francesca points to several dilemmas, influenced by her own bereavement, especially after 32 weeks. From her story, we can elicit that the deciding factor for participants endorsement of abortion in most cases – the acid test, it seems, is if the baby would have been compatible with life and this is something Peter elaborates on. He feels less morally complicit in wrongdoing but acknowledges it as a *"a grey area" (195).* Francesca's recollection reinforces Czarnecki's (2021) argument: that personal circumstances impact on conscientious objection. The conceptual model devised by Czarnecki et al. (2019) on 'moral work' pays more attention to decision-making mechanisms that are relevant to Francesca, who talks widely about the impact that her bereavement had on her family. It shows conscience as an emerging, iterative process influenced also by personal lived experience in social and institutional contexts. Whereas most research focuses on whether healthcare workers <u>should</u> be required to provide care that maybe violates their conscience, Czarnecki et al.'s work explores <u>how</u>, which is equally complex. In

Francesca's case, her objection would be circumstantial, she cites 32 weeks as the benchmark, attributing value to the life and her interpretation of when it is viable.

There is certain convergence between Jane and Anna's views on viability in recognition of the gravitas of abortion decision-making, *"because it is about a life" (Jane 131)*. In her rationalising, Jane seems to be drawing on aspects of self-reflection which feature in the framework on how midwives morally reason about abortion asking - 'Is it necessary, fair and justified?' rather than simply 'Is it legal?' given midwives' interpretation of the varied status of the fetus. This implies moral reasoning may well be primarily centred around thoughtful objections (based on internalised, thought, and moral processes), before making professional obligations (based on instructive or prescriptive recommendations from others).

Jane also draws on Consequentialist ethical principles, which she uses to conceptualise the repercussions of her decisions. In ethical philosophy, consequentialism is a class of normative, teleological ethical theories that hold that the consequences of one's conduct are the ultimate basis for judgment about the rightness or wrongness of that conduct. In this approach a morally right act (or omission from acting) is one that will produce a good outcome. There is a great balance of good over harm (one of the basic tenets of Consequentialism) for all participants in supporting women's choice. Where the dilemma seems to arise is in the idea of personhood and the extent that harm to the fetus is ensued, akin to which Laura's antenatal patient asks, *"You're talking about murdering my baby, aren't you?" (53-54).* Note the status and propriety afforded both conceptually and linguistically to 'my baby' (rather than a fetus or pregnancy) before birth here. Thinking of the fetus as a baby arguably personifies the life being terminated, rendering dilemmas more emotive and morally complicit, as Romanis (2015a/2015b) and Mackintosh (2014) suggest. Loaded value judgements centre on what is classified as a 'Life of Value' and on which criteria is this potential based – having a "full, full life".

7.3.2 Living A Full, Full Life

Potentiality relates to latent qualities or abilities that may be developed and lead to future success or 'usefulness'. Potentiality predicts value in the ensuing life of those affected and gauges risks, in a Benthamite pursuit of happiness. In the GET 'Fearing Reviving, Surviving and Thriving,' dilemmas, perhaps more acute at, say 23 + 5 weeks, are tortuous to the midwife when predicting potentiality theorised in the literature (Hare 1975; Morgan 2013; Marquis 1989/2001; Brown 2000). Threads of the Aristotelian "golden rule of abortion" are woven throughout the data and can be applied to moral

reasoning by theorising if the fetus will manifest property and realise it's potential. The trajectory from being a nascent entity to possess all attributes as 'full persons' later in life, presumably, with all the rights, responsibilities and contributions that accompany it finds voice in the data, for example, here in this "Living a full, full life" quote from Betsy (112-113).

The trouble with arguments of potentiality is its subjectivity – who is responsible for judging and based on what criteria? Whether the baby faces a long life of value or one of suffering and dependency is a difficult responsibility to shoulder. The complexities are discussed by Peter, regarding "*a potentially healthy fetus" (Peter 488)* and Jane (400-406) who rightly point out the importance of consultation, supportive, therapeutic relations, and respecting *"whatever the woman wanted at the time" (Jane 406).* Of course, this is determined by professional medical advice. Betsy, Ivy, Karen, Laura, and Jane's data are rich in examples of different scenarios where congenital conditions may impact on conscientious objection decision-making – a minefield of differential diagnoses. Laura enlightens us on how life limiting conditions still are reasoned to have a quality of life and value in that life,

"People think we shouldn't have the power to say who lives and who dies. Erm, and for whatever reasons, whether it's a handicapped child that does not have a full life ahead …have we got the right to choose – who lives and who dies? For my child, in that situation, yes, I think I have." (Laura 123-138)

Realising that outcomes of one's management at birth have long-term implications for all of another's family, should the midwife intervene? is a dilemma in itself. The onus is on the first responder to 'do the right thing, right'. In deciding, not only clinical, but legal, professional, theological, developmental, ethical, and even philosophical questions must be answered – a lot to share with colleagues but mostly with the woman at the bedside. Section 2.7.3 discussed this Foucauldian pedagogic shift (Fahy 2002) and how empowerment has been "increasingly used in the midwifery context to strengthen the woman and her family" (Hermansson and Mårtensson 2011: 811). According to one of the statements in the code of ethics for midwives,

"Midwives work with women, supporting their rights to participate actively in decisions about their care and empowering women to speak for themselves on issues affecting their own and their families' health within their culture/society." (ICM 2024: 1)

Even in the most tragic of circumstances, we should aim for the kind of positive patient experience with support, compassion and kindness, that our service-users feel all has been done that could be done for them, their views have been taken into consideration and their wishes respected.

7.3.3 Medical Marvels of 22 Weeks

Perhaps the last word should be given to Peter, whose metaphor, as if submitting a response to a thought-provoking essay title *"Discuss"* highlights the contentious and unresolved nature of freedom of conscience as a phenomenon. What works in one scenario might be irrelevant in another. What suits one person may not suit another. A whole set of values in one scenario may appear less appropriate in another.

Given there are examples of babies who are "*medical marvels of 22 weeks who survive and become babes" (Gillian 89-90),* 'Fearing reviving, surviving and thriving' is a very real dilemma. These kinds of conflicts could signal potential or real deterrence to participation in abortion, especially if one carries preconceived ideas about fetal sentience, humanness, and convictions about rights to life,

"Interviewer*: It's tricky, isn't it? I suppose it depends on your views of when life starts.*

Peter*: yes (nods in agreement), I guess that's the religious thing. You know, whether it's divine, I suppose. Hmmm – 'When does life start? Discuss." (Peter 107-110)*

This is where the framework of moral reasoning (see table 8) may be able to alleviate some of the moral distress associated with contentious, singular, ethical decision-making. In looking inwards (asking oneself) and outwards (asking others) the benefit of this is to bring some consensus and solidarity to the ethicist's reflective toolkit.

7.3.4 CO Crises at the Cusp of Life

In asking the rhetorical questions paralleled in philosophy (Singer 2014; Cantens 2019), Peter makes theory real and impresses the lived experience of midwives to the reader. They make sense and meaning in the clinical picture which reminds us that in the literature review, Savell (2007) suggests that 4d imaging is changing ideas of personhood, humanising the fetus' status "responsive…capable of complex behaviour". Part of the dilemma of potentiality could be said to consider the 'Peter Singer Journey Model of Life' (Lazari-Radek and Singer 2014) which advocates the taking of life at its beginning when no goals have been set. At the earliest opportunity, there is less wrong

because as a person, there have been no accomplishments. Singer's principle: if we can prevent something from happening without sacrificing anything of comparable moral importance, then we ought to do so, denies the automatic right of the fetus to life. Singer's principle also dismisses potentiality as well: that cognition is developing. In the data, Peter's assertion that the life being aborted "*They're not just a clump of cells either"* (Peter 108) seems to support this, highlighting midwives' CO crises at the cusp of life.

Conscientious objection has been intimated as a transient and developmental concept, with attitudes evolving over time. Brock (2008) argues that this moral integrity should be respected as a deeply held conviction, central to personal identity, moderation may be difficult. In the data, participants sum up the longevity of such entrenched views,

"If someone does have these strong beliefs, they haven't happened overnight." (Catherine 201-202)

The concept of 'CO crises', however, relates to those scenarios where conscience matters erupt. From the literature surveyed, Birchley (2012: **13**) comments on these:

"Pangs of conscience, useful in rapidly unfolding situations."

The element of the decision-making being time-bound is apparent in Peter's insight,

"It's seven o'clock in the evening, you've rocked up on Labour Ward …. all of those thought processes have to happen very quickly. 'What's the situation? What's the scenario? Oh okay. Hadn't really thought about that - oh! Gosh!" (Peter 209-215)

The idea of CO crises builds on Chervenak, McCullough and Brent's (2011) idea of the obstetric dilemma. When a human being without independent moral status can be properly regarded as a patient and when it presents to the physician, there is a balance of clinical benefit over harms brought into question. The idea being that pregnancy is not permanent but a time bound state, contributes to pressures on midwives' decision-making in a timing dilemma. The most acute of these dilemmas – in resuscitation of a viable fetus at ever earlier gestations – may be seen as a deterrent to midwives' willingness to partake in abortion. Their hesitant reluctance is one of the main areas that this thesis urges some rethinking of conscientious objection.

What comes from the data is a very phenomenological view (a Heideggerian concept of *In Being and Time)* of rapid assessment, not dissimilar to a midwifery triage, spontaneous moral reasoning, and ethical decision-making '*on the hoof*' as it were.

Anna's CO crisis relates to obstetric emergencies, but it is too simplistic to define a CO crisis only in terms of urgent clinical need, which it is not. Despite "*Very serious consequences for the woman if we don't just crack on and help her." (Anna 182),* CO crises are mainly practitioner centric. Faced with acute dilemma of what action to take, there may be dire consequences for the midwife's moral integrity and psychological well-being. They are exacerbated in emergencies becoming more extemporaneous, with less opportunity for moral reasoning because of urgent necessity. Betsy highlights there is less justification for conscientious objections in critical situations, where the imperative is to care, and for that care to centre on the pregnant person,

"Like that, that doesn't even bear thinking about really because you are saving her life. I know she's probably in that position because of, urrm undergoing a procedure, but…." (Betsy 165-167)

The law supports the premise. Originally the Act did make provision for opt out but this is not applicable in emergencies. Supplementing section 4 (1), 'the conscience clause', section 4 (2) states,

"Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."

7.4 Theme 4 - Being Torn Between Wearing 'Two Hats'

Ivy illustrates the dichotomy of maternal versus fetal rights to life, with a moving story of one dying service-user she looked after. The case highlights how incongruent interests may be and how inter-dependent life is. She cites that the woman chose not to deliver when she herself was faced with her own mortality for the sake of the other siblings and the baby's father. In deciding whose rights ought to take precedence, in British law, the main accent is on saving the mother's life, but this is not always the same the world over. Ethically, doing good invokes least detrimental outcomes, though assessing what the harms are is inherently complex, "*Unfortunately to save a mum's life, the best thing to do is to take baby's life",* states Ivy (171). Ivy's example strikes a chord in women

activists who remember the freedom of conscience case of Ana Maria Acevedo, the details of which feature in the case study (see Appendix 11).

Gillian also expresses the quandary of weighing up pros and cons associated with participation dilemmas as feeling *"torn",* a metaphor which invokes imagery of shredded, ill-fitting sides of a dilemma. Being in two minds, with a ripped and jagged edge, spilling out feelings is a far cry from a standardised uniform or a mechanised *"robot" (Jane 156).* Calculating the risks and benefits of actions indeed has an emotional cost, Gillian implies. Her comment "*Catholic (and all the rest that goes with it)" (43)* is both an interesting linguistic and conceptual add-on here. One can surmise what Gillian means in as much by what she does not reiterate – might this incur an ethos of charity or be comment on societal attitudes? She implies in what she leaves out, that there is more to religion than faith – possibly observance and the expectations of a Roman Catholic – with its implications for ethical dilemmas and moral reasoning. 'Pondering' is a deep contemplation, a nursing reflection, rather than fleeting glimpse of Gillian's standpoint. It is a verb which highlights how residing opinions may evolve over time for a practising midwife, practising religion. The professional ethos versus personal beliefs dilemmas which feature in this theme centre on the person inside the uniform. What happens when midwives like Gillian "ponder" and self-question 'Do my employer's, profession's or institution's requirements contradict my own values? Am I in the right job, am I doing the job right? Can the midwife really isolate her feelings on this?

7.4.1 Putting Things into a Box

Harris et al. (2016) support suggestions that associated taboos, prejudicial attitudes and societal norms accentuate the complexities associated with moral decision-making and expression of freedom of conscience. As research shows (Harris et al. 2016; Lamb et al. 2019), in morally inclusive, emotionally intelligent environments, part of the way midwives cope is to put their feelings to one side, a plethora of influences that some participants liken to being put on a backburner, "boxed" in Pandora type storage.

In fulfilling two roles, Gillian captains some objectivity. In not quite "*giving up beliefs" (66)* she acknowledges the contention yet urges an impartiality needed to deal with participation dilemmas. Diane calls this detachment *"becoming desensitised (*because) *it's just a procedure" (147).* Nevertheless, despite the distance, lived experiences of ethical dilemmas remain evident: *"A very difficult thing to process. At the end of the day, or to leave behind you"* says Diane (148).

"*Behaving in a professional way" is what the profession needs you to be as well as what the woman needs you to be",* states Betsy (77-79) suggesting that ethically sound practice and a harmonious balance of rights are achievable. What Betsy (233-239) alludes to here, is that reproductive health deals with two lives, but in her estimation, as in law, the needs of the service-user take precedence. Two lives intertwined whose fortunes may be destined to be torn apart. Like Peter, Betsy implies the moral distress is less pronounced or easier to manage if the termination is on medical grounds and the baby has poor predicted outcomes. What Betsy and others do not expand upon is what happens if the semantic spills out of the box or hypothesise about its consequences. Certainly, Betsy remarks that the right midwife delivering the right care is imperative. This leads us to the idea of what constitutes professional behaviour, and there are many references to midwifery values, like 'Ensuring the Patient Comes First'.

7.4.2 Ensuring the Patient Comes First

Assumptions around promoting values, principles and ethos of a profession may well vary. Generally, it is taken to mean a paid occupation (not a pastime) which involves formal qualification. Some degree of talent 'profess'-ed is added to being conversant in the body of knowledge. 'To profess' in its Old French form of Latin means to be proficient in a skill, that is, prayer hence the religious connotations with ceremonial undertones - professing a faith. Actions of practitioners are monitored by a regulatory body to ensure good conduct. Compliance with a commitment to maintain standards is a feature of Jane's data. 'Being professional' helps achieve high quality results, in doing a service and providing ethical goods. In addition to technical skillfulness and competency, conscientiousness could be viewed as one of the core characteristics of being a professional – which brings into play integrity, respect, and emotional intelligence as components of ethical decision-making.

"*As a midwife, that's at the core of what I do. It's facilitating bodily autonomy,"* states Peter (118) on professional values. Others are less convinced that the midwife's role should incorporate participation in abortion beyond that of obstetric nurses or gynaecology-based specialist services, an argument which shouts of unclear boundaries in the 'matty/gynae' divide. What is legal, what is professional and what is good conduct features heavily in moral reasoning around professional tasks. Elements of how midwives react to dilemmas they encounter feature in Table 8 framework, as midwives address the mechanisms of ethical decision-making. As a collective body, in the data, midwifery is alluded to as a single entity, for example, here by Hannah, but is midwifery really so homogenous as to be able to facilitate a wholesale service for disparate need?

“Yeah, I think we, I think as midwives I think most will refuse to have that on their conscience,” (Hannah 207-208)

Beyond this it is noteworthy that Peter feels a duty-bound obligation in defence of the position as an abortion-supporter by conforming to professional values, but his position is made all the more astute because of his gender,

“I feel that it wouldn’t be acceptable for me to have a conscientious objection, really, how could I justify that, having been admitted to the profession? As a man, how can I turn around and say, ‘Actually, I think this is wrong,’ you know, it feels an untenable position.” (Peter 123-125)

As midwives, participants assert recurrently that being “with woman” is the fulcrum of midwifery practice. Part of woman-centredness is ensuring the patient comes first, a principle widely adhered to, despite objection when *“There is a pull from the workload infrastructure versus the individual’s need.” (Catherine 93-94)*

By choosing a midwifery career, with its commitment to caring professional values, for Maria, places focus on the woman. It is almost as an assumption around abortion being part of healthcare that the midwife’s role accommodates choice,

“I suppose, if you are part of midwifery- then a lot of focus is on the woman and should always be on the woman. So maybe, I have already made that choice. I feel like I have already made that choice before.” (Maria 59-62)

However, this is one area of divergence with data from other participants. Few participants anticipated an abortive role or had previously considered objection. Many state they opted for a midwifery career based on pre-suppositions around saving life, not participation in abortion. Professional bodies like the Nursing and Midwifery Council recognise this (NMC 2021). Paragraph 4.4 of ‘The Code’ states that nurses, midwives and nursing associates who have a conscientious objection must tell colleagues, their manager and the person receiving care that they have a conscientious objection to a particular procedure. They must arrange for a suitably qualified colleague to take over responsibility for that person’s care. The onus, being on duty to refer, highlights that CO is apparently an exception rather than a rule. Paragraph 20.7 of the Code requires nurses, midwives, and nursing associates to make sure they do not express their personal beliefs (including political, religious or moral beliefs) to people in an

inappropriate way. This expression may be in any format including though the use of social media, responsibly, always respecting the right to privacy of others.

A profession acting en masse, in unison, alluded to in the literature, (Beauchamp and Childress 2013) in the debate is referred to as 'institutional CO' by Fernandez-Lynch (2080). But is this legal, justifiable, or right? Like Symons (2020), who argues whether institutions have consciences which can be violated, Jane is mindful of the importance of protecting integrity as a means of preventing harmful consequences for society. Both Wicclair (2011) who considers 'monopolistic privilege' and Cholbi (2018) who coins the phrase 'public cartels or private conscience', warn against the dangers of disregarding patient interests if professionals are given *carte blanche.* Not dissimilar to midwives, Schuklenk and Smalling (2017) voice concern over a patchy service, detrimentally affecting aggregate accessibility, undermining public confidence. Professional conduct and institutional reputations are never far from Jane's organisation-centric view, but she still considers the individual at the heart of conscientious objection.

7.4.3 Respecting Different Views

We have discussed in the literature review, under the Rawls' principle of reciprocity (2005: 45-50), how health care practitioners are granted the 'right to stick to their deeply held moral or religious beliefs' as long as they grant the same right to anyone else (requesting or providing the controversial treatment), their beliefs are not intolerant (Sulmasy 2008) and do not violate plausible requirements of social justice (Brock 2008; Sulmasy 2008). This is at the heart of Betsy's care philosophy.

Rawl's theory of 'Justice as fairness' describes a society of free citizens holding equal basic rights and cooperating within an egalitarian economic system that does not overlook the disadvantaged (Rawls 1999). Under conditions of reasonable pluralism, the mechanism by which he demonstrates this is called "overlapping consensus", similar to one of the tenets of democracy. Rawl's conception of justice comprises two main principles: liberty and equality (subdivided into Fair Equality of Opportunity and the Difference Principle. This 'diffusion up' theory regulates inequalities: it permits only inequalities that work to the advantage of the worst-off, like positive discrimination). It is in bridging divides, Gillian states, that she,

"*Believe(s) people have the right to conscientiously object. I might not like it, but I do believe they've a right yeah?" (Gillian 145-146)*

No matter how repugnant their decision may seem to the onlooker, it remains an issue of democracy, (even if they change their mind) in providing impartial, non-judgmental care. Like the adage, attributed to Voltaire, ‘I may disagree with what you say, but I will defend to the death your right to say it’, Gillian champions tolerance, diversity, and inclusivity. She is always mindful of a unbigoted attitude to freedoms through a Universalist lens. Similarly, Betsy places respect at the fulcrum of Egalitarian principles,

“Respected - that's what I see...I wouldn't judge somebody for saying, you know ‘I can't. I can't do that’. I need to respect that.” (Betsy 212-218)

There is convergence with between Catherine and Betsy’s data on this point – fair allocation (212-215), confidentiality (48-53), recognising boundaries (271-274) and an acknowledgement rather than assumption (446) are all part of the way Betsy deals with objection. Her balanced and empathic approach comes to light when again she reflects on fairness,

“*I would never ask somebody to do something I wouldn’t do myself.” (Betsy 256-7)*

7.4.4 Being a Midwife in the Room - What? When? Who Should I Tell?

If one PET could sum up the phenomenological essence of the thesis, it would be this one, which more than most represents the lived experience of dilemmas. Although there is a sense of objection being suppressed, contained, and put into a box, the law on conscientious objection is quite clear: open declaration is encouraged. In respecting midwives’ rights to freedom of conscience whilst ensuring coverage of services, timely declaration enables managers to allocate staff accordingly. Section 4 (i) of the Abortion Act states,

“Provided that in any legal proceedings the burden of proof of CO shall rest on the person claiming to rely on it.” (Legislation 2022)

Handover dilemmas point to disclosure difficulties – who do I tell about my objection, what, where and when? What are the implications for my colleagues when faced with a CO crisis or conflict at handover of care? At what point should I say, “*Look, I don’t want to go in there!”* Betsy takes a very task-orientated perspective here, in delineating what participation comprises. It is as if midwives’ objection represents a radicalisation and politicisation – a mark of the assertion of their autonomous practice. Betsy sums up how blanket objection rarely occurs, but sometimes midwives can be dismissive, intolerant, and non-understanding. *“You're a midwife and that's it!” Betsy (104-105)* tells us of a

common reaction which predisposes the questions ‘Where do I find support?’ ‘To whom do I turn?’ ‘What is the impact of my objection?’ and ‘How can colleagues be encouraged to be more tolerant?’

Whether at point of employment or before taking over care, both Catherine, Maria and Nancy's opinions converge in accordance with professional guidance: that the service-users ought not to be aware, disadvantaged or placed unduly at risk because of conscientious objection,

“Everyone needs to be aware of that, because it impacts everything. That impacts on an emergency and a lot of stuff in healthcare.” (Nancy 231-233)

The benefit of the case-by-case decisions “*at a given moment in time” (Catherine 95)* (as opposed to blanket objection) is to incorporate flexibility. This brings with it the potential for the kind of selectiveness, discrimination, and inconsistency that conscientious objection is so heavily criticised for (Savulsecu 2006, Smalling and Schuklenk 2019). Dealing in an ad hoc way may precipitate CO crises or worsen the moral distress they cause. Peter (209-215) describes the scenario as a kind of *“Oh Gosh!”* shock.

For the women’s sake, equity is important, enshrines constitutional rights and ensures everyone feels they are treated in a non-discriminatory way but where does this leave others when practitioners object, saying *“No we’re not doing that one”, (Hannah 196).* Justice and fairness dilemmas look at whether or not the act is justifiable? Am I being ethical and treating everyone as equals? How reasonable are decisions in relation to non-judgmental care, fair realisation of choices by all parties case-by-case?

In skirting around the terminology of participation, which Peter refers to as “*walking the walk” (377)* and *“doing the deed” (372)*, Peter gives a sense of the ‘unspokenness’ of objection in which taboos are perpetuated. This is one of the closest examples of the operationalization of procedures, yet Peter seems to circle around definition of the word the abortion, presumably to drive home abortion’s sensitivity. Betsy agrees, the smooth working of all service provision relies heavily on the co-operative contribution of all team members (especially where there is potential for conflict, in tricky areas like conscience). The above statements epitomise findings – that midwives are not averse to abortion or facilitating woman-centred rights, because they veer from any objection which negates care, but this is with limits, mostly on the basis of gestation and justification. This is as

the current law stands, provided for within the four criteria of the Abortion Act, which the next GET will examine more closely.

7.5 Theme 5 - Two Signatures and the 'Escape Clause'

As well as relying on their professional guidance, midwives are mindful that the contentious nature of abortion care may land them in court. Arbitrary criminalisation of providers has been mentioned as one factor which recentres discussion in the subject area (Ambast et al. 2023). Part of the conscientious objection quandary is in its lack of clarification in law (Will 2013).

"Where we may end up recognising a right to disobey the law. I argue that there is a right to conscientious objection and that this may be justified through the notions of autonomy and integrity, which a liberal democracy should respect,"

states Ortiz-Millan (2017: 1). This thesis maintains the same position: namely that carefully regulated freedom of conscience need not necessarily conflict with women's reproductive rights or be a threat to the (albeit precarious) status quo of abortion rights. It may yet be a requirement to be metred out – to which procedures, by whom and how objection is permissible. Accessing services could be rendered streamlined without CO being a contention of exemption. Accommodation of freedom of conscience is not a boycott, it is a recognition, a realisation of rights. Although essentially their views of 'dishonourable disobedience' may be opposite arguments, on this point Fiala, Arthur and Ortiz-Millan do converge in that statutory intervention is required to redress imbalances at institutional, national, and international levels. Tongue (2022) explores a similar international human rights framework, urging states to adopt mandatory referral mechanisms where objection is permitted, often circumvented by professionals to "strike a contextual balance."

The Scottish case of two midwives who took their employers, Greater Glasgow and Clyde Health Board (GGCHB), to court highlights these dilemmas (Harmon 2016). Harmon (2016: 143) describes the case as a "missed opportunity for an instructive rights-based analysis", which he states,

"Failed to engage holistically with the foundation of conscientious objection and its position relative to the competing right to adequate healthcare, a failure which must be seen as a lost opportunity given the manifold threats to timely access to abortion."

Ultimately the Supreme Court ruled in favour of the employer, calling for closer definition of the term “participation”, what comprises actions that actually contribute to fetal demise (Fleming and Robb 2019). Although the Bill aimed to “give shelter from compulsion” (Oderberg 2018), it failed largely because of the language of ‘participation’, suggests Oderberg, which should be substituted by terminology such as ‘performance’, ‘assistance’ or ‘co-operation’ to reassure the uninitiated.

This featured as one of the knowledge gaps which this thesis hoped to address. As a response, in the ‘Model CO Definition’, part of the ‘legally aware model’, therefore, highlights midwives’ are keen to support the law, providing legal definitions of objection that include issues of human rights used as a decision-making tool (see page 283-284). For Gillian, the opt in/opt out is based on all parties freely having access to information, a pre-requisite to ethical decision-making and for her colleague, Diane,

“How they came to that conclusion… working within the parameters of the law.’ (Diane 263-264)

Like the Royal College of Midwives, the BMA (2019b) supports removal of criminal sanctions for abortion, detailed in section 2.7.7 which listed the BMA’s justification in its position statement. Further, “Expressing Your Personal Beliefs as a Doctor’ (BMA 2019a) clearly spells out the British Medical Association advice to medics on employment, yet the BMA guidance is criticised by Adenitire (2016) as contravening ECHR human rights law because the lack of emphasis on mandatory enforcement to provide for conscientious objection which make it imperative for NHS institutions to do so. It is only possible to speculate why this may be – presumably a lack of enforcement leaves open a pathway for local arrangements, such as ethical committees, review boards and tribunal systems. Lacking enforcement affords a certain flexibility to ethical decision-making to address practitioners’ dilemmas when, as in wider health spheres of practice, they reflect – is it legal?

7.5.1 Is it legal?

There is overall support for the Abortion Act. On the whole, participants approve of it’s flexibility, feel it meets contemporary needs though its lacking facilitation of the specific role of the midwife is mentioned. Like Gillon’s (1994) analogy, (the view that there is no special privilege as a healthcare worker to break the law, even if one disagrees with its moral justification) is widely maintained. Jane’s focus is more on professional matters, yet mindful of public safety: the second doctor requirement being a quality assurance,

and a failsafe. Protecting the practitioner, protecting the public yet fulfilling individual wishes is a fine line to traverse, it seems.

Despite this endorsement, some participants do voice criticisms about the Act's effective application in practice. Peter questions whether in its administration, two signatories could be midwives especially since most assessments are for social reasons. The advantages of this may be quick and easier access, streamlining services as there are more midwives. This reduces the need for unnecessary involvement, but referrals still are required unless midwives participate more pro-actively and extensively in abortion. Some would say this is a slippery slope – a backdoor route to further unfair divisions of labour given concerns about workload distribution expressed in the data (Anna, Nancy). Stark international comparisons are used to poignant effect, albeit stereotypical. Peter expands on this idea that objection costs lives as readily as: *"The right cocktail of circumstances and then if one of those triggers is a murder, it's one of those trigger issues." (Peter 159-160).* In Peter's choice of metaphor, he implies a wanton peril, or loss of control – creating an avalanche skiing down a snowy bank: *"Revoking the right to abortion, then it's a slippery slope." (Peter 161).* Karen and Jane converge in expressing reservations about making Abortion Act criteria more lenient, however, to reflect the gravitas of abortion. What Karen does not expand upon is the extent to which those current needs are changing.

7.5.2 Understanding the Conscience Clause

Out-dated, better suited to a Victorian age and designed largely by male lawmakers in a more Patriarchal society (criticised for being by men, for men), Gillian has a better medico-legal insight than others into the relevance of the conscience clause to midwifery practice. Gillian describing the conscience clause as *"an escape clause" (410)* is a metaphorical tour de force implying practitioners break free from confinement. It implies professional obligations are a Boama (2008) - type oppression or control avoided by using loopholes in the law. The imagery conjured up is bolting from imprisonment, absconding from Alcatraz duties and responsibilities, *"there to save a life." (Betsy 173)*. Having made the bold assertion, Gillian then reigns in her remark and reminds us as readers that objection is not always such a reckless abandon. Gillian suggests objection creates complex dilemmas. By having said a simple 'no' – the assertion could (and should) be compromised. She makes a moral judgment about objection *"running risk(s)"* rather than resolving them, *"in our own medical practice in terms of it's an emergency." (Gillian 214-216)*.

Despite such reservations, the premise of this thesis is that accommodating rights, if suitably regulated, if more openly formalised for midwives, might save lives. Recognising conscience is not a red flag to dismantling legal abortion.

7.5.3 A Fresh Look at Conscience Policy

This section links rights to the legal implications of Abortion Act policy and how this might impact of ethical decision-making. It has already been stated that policy aims to standardise care, communicate best practice, and provide an evidence-base. Policy translates the law's requirements into practice. Policy protects practitioners and promotes safety for the public, but conscience policy is less easy to evaluate since in the areas studied it does not exist (or at least midwives are unaware of it).

By using terms related to 'enforcement' and 'policing', Peter (517-525) implies compliance within the law and reiterates midwives' obligations to observe the rules. In freedom of conscience terms, Peter's choice of words impresses regulation in our minds – sharply contrasted to the "messy" world of midwifery (and more specifically the NHS environment). He tells us, "*We all like a guideline, we all like a policy, makes us all feel comfortable and that's obviously going to make life better for everyone." (Peter 524-525)*

Gillian's comments (239-250) suggest that merely signing up to the profession, and more locally, to the organisation is an endorsement of a set of values, a commitment to its policies and guidelines. She is doubtful about how a specific conscience policy may help the evolving dynamic that is abortion, because as Maria shows, conscientious objection decision-making is fluid and changeable,

"Yeah, and what might be right for me today might not be right for me tomorrow." (Maria 36-37)

Because of the nuances of practice, one size of policy may not fit all. Peter likewise criticises policy as prescriptive. The idiographic nature of moral reasoning calls for greater flexibility and independence, not less. What greater compulsion is needed than the incentive to save a life, Gillian reflects.

Midwives' rights and freedoms, however, are unlikely to be realised without a fresh look at conscience policy to address rights-related dilemmas. These relate to what rights are paramount, accrued to whom and whose entitlement should come first – those of the fetus, mother, midwife, employer, or society?

Although protected by law and enshrined in the UN Convention of Human Rights, some suggest it is a kind of state interference:

'*That centralisation over women's rights of the choice over their bodies" (Diane 130).*

Given the tenet that healthcare is a universal human right, then what comprises abortion rights specifically and women's rights generally feature widely in the data. There is one argument which suggests that pregnant women are not necessarily sick, that pregnancy is a normal, physiological state (rather than a disease or condition), so medical interventions are not necessarily indicated. Whether abortion forms part of healthcare, or ought to, is outside of the remit of this thesis, but considering the issue raises questions about equitable entitlement to care (and midwives dilemmas regarding their role within that premise). If statute and NHS constitutional values align with anti-discriminatory policy, it follows that healthcare is free at the point of access, delivered universally for all. If we are to maintain the principle of 'to each according to his needs' might not necessarily collate with receiving 'whatever we want, whenever we need it', because of the implications for others. It is impossible to distinguish between care needs based on other lifestyle choices. Whether we smoke, drink, eat to excess, misuse substances, or have unprotected sex are amongst many habits that one could argue are civil liberties. The core concept relates to ideas about bodily autonomy, propriety, and the role of the state circumventing individual freedoms. Conscientious objection empowers midwives enacting medico-legal compromises to their unwilling participation in dealing with unwanted pregnancy. If midwifery is, as Jane, Nancy and Maria maintain, a matter of empowerment, then rights are pivotal. Midwives, however, are shown to feel caught somewhere in the impasse of whose rights are right? And if right, whose rights take precedence?

There are many different rights addressed in the data – including broader aspects of paternity, disability, employee, civil and fetal rights. Anna (73-77) sets the ball rolling when asked if conscientious objection is a women's rights issue. In thinking about third party stakeholders, her reply focuses on rights to self-determination. Abortion, she maintains, is the realisation of reproductive justice, in which the woman is the primary agent. The healthcare professional (as a mere means to an end) is less morally complicit and redundant in the decision-making. But the links with criminal acts – rape and abuse - drive home the imperative and take away the element of elective choice about the conscientious objection. None of the midwives would object under these circumstances.

On this basis all participants adhere to the premise that abortion is predominantly a service-users' health choice, above all else, and they do exclude other third parties.

This is not without regard for fetal rights, but the strongest emphasis is on bodily autonomy for the woman. Chervenak, McCullough and Brent (2021) explained the fallacy of this reductionist model, which is where their professional responsibility model of obstetric ethics may have something to contribute to the discussion: emphasizing the importance of medical science and compassionate care overriding extreme clashes of rights,

"It's just part of the package of autonomous bodily rights, which I believe every person should have.'" (Peter 34)

From the literature review, we can draw from Tooley et al.'s (2009) 3 perspectives conceptual model here. Betsy and Peter's dictates (that the woman's body belongs to her, and she can control what happens to the fetus) seem to support a liberal pro-choice approach, rather than communitarian and gender justice approaches (which centre on the status of the fetus). In sharp contrast, Maria, might be said to veer more towards Gensler's (1986) critique of Tooley with her ideas of the fetus being *"housed"* and the current status of the fetus having "no more rights than a mouse fetus."

Dilemmas relating to exercising rights to freedom of conscience as the main topic of the thesis is beyond doubt, but the interview schedule did not specifically feature questioning on 'rights' per se. Nonetheless, without exception, all participants' first responses mentioned rights, hand in hand with conscientious objection. This is then illustrated by a variety of scenarios where promotion and protection of fundamental freedoms spring to mind. The resulting dialogue therefore presents a colourful kaleidoscope of human rights: not solely confined to whether the woman's or fetus' rights are hung in the balance – but third-party rights – such as father's or the health care providers' or the State's rights, duties, and obligations. Together, analysing these comments may well draw to a close the section on what policy comprises, yet they open up the research forum, for broad consideration in a global context, the contemporary debate relating to wider women's health.

7.6 Theme 6 - The Right Midwife, Delivering the Right Care

Solutions which support midwives, supporting service-users addressing the way forward are the focus of the final GET. The title originates in comments made by Betsy, who with

her substantial length of service in women's health, provided strong data on objection management,

"That woman is just as important, and she needs that care. She needs that care from the right person." (Betsy 110-111)

Acknowledging some semblance of conscientious objection is here to stay, lessons learned and options for better accommodation of rights were explored including:

- Appropriate allocation of staff with essential skill mix in adequate numbers.
- Training and orientation to freedom of conscience rights.
- Curriculum building using a more sociological and psychological model.
- Appropriate referrals.
- Facilitating support in the workplace, for instance through Professional Midwifery Advocates (PMA).
- Registration of objectors.
- A human resources approach based on an A-EQUIP model (an acronym for Advocating for Education and QUality ImProvement).
- Ethical Committees and Healthcare Safety Investigation Board (HSIB) type reviews.
- Values clarification workshops.
- Patient liaison forums.
- A compassionate attitude.

7.6.1 Achieving a Harmonious Balance

Without acknowledgement of the phenomenon and recognition of its potential to detract from care provision, progress on accommodation is likely to lack foundation. Like McLean (2013) who advocates a move away from entrenched attitudes, Betsy staunchly pushes for transparency and openness. Catherine sees it as one aspect in which midwives may need to move away towards "*a supportive conversation" (Catherine 292).* Objections should *"not end up an assumption" (Betsy 448)* or a *"given'' (Betsy 278).* Betsy expands on ideas as an integral part of workload allocation. Accommodation is not just seen as a question of adequacy – 'a numbers argument' of quantity, having sufficient, aggregate human resources to effect coverage, but appropriate skills mix. Similarly expressed in the literature, midwives' concerns focus on the effects of conscience on accessibility and availability which in some countries can be patchy. The global and UK context was earlier compared (Dobrowolska et al. 2020; Jones and Chiu

2023; Minerva 2017; WHO/UNFPA/ICM 2021). Participants do the same. Many international comparisons are made by them to highlight that when freedom of conscience is sporadic, it can have catastrophic and tragic outcomes – the case of Ana Maria Acevedo demonstrates that (see Appendix 11). A more considered view, as participants seem to be divulging, is that an acknowledged and properly regulated system of accommodation endorses safety and patients' sexual and reproductive choice. Facilitation supports rights to be cared for appropriately and indeed, cared for well. Betsy's alignment to staff rights is akin to caring for the carer in a positive and impactful way on care.

Literature supports that associated taboos, prejudicial attitudes and societal norms can negate a therapeutic relationship with the service-user (McLean et al. 2019; Harris et al. 2016; Self 2023). Transcripts are rich in references about grievances, bullying and breakdowns in communication both within multi-disciplinary teams and with service-users where conflict or disagreement dilemmas may materialise. Catherine, for example, talks of receiving feedback from patients whose main complaint centred on the fact that they felt the professional caring for them did not agree with their decision to terminate the pregnancy. The danger is of care becoming unethical, psychological distress being heightened and harm becoming an accepted feature of service provision by the communication of this disapproval, (albeit inadvertently). This thesis maintains discord accentuates the complexities associated with decision-making. One on one conflicts in conscience-based refusal pit the service-user against practitioner. Ultimately the dilemma affects moral reasoning at key points in the abortion journey, but participants are keen to stress even objectors do not wish for that. Whilst non-objectors themselves, all respect alternative positions to their own, acknowledging the bravery of declaration.

"Well done for saying, "Actually, I'm going to hold my hand up and go. 'I can't do this!'" exclaims Francesca (155).

Peter faces his own conjecture when, he discusses how he anticipates his objection may be received: *"I could just see the tumbleweed as everyone would just stop and kind of look and go, 'Wow!'" (Peter 141-143).* The "tumbleweed" – a linguistic metaphor perhaps for his feeling fuelled by conscience storms, directionless and at the mercy of the winds – makes the *"untenable"* position ever more vulnerable.

Greater understanding of differing perspectives is key. In a letter to the Irish Times, De Londras (2018) writes,

"Respecting people's deeply held beliefs, finding a way to balance that respect against the needs and beliefs of others, and resisting compulsion and domination is the essence of pro-choice thought."

Similarly, the focus of Stifani et al.'s (2022) work looked at the successes and challenges of establishing hospital-based services in Ireland following repeal of the eighth amendment in 2018. The contribution of 'values clarification workshops' was assessed to be wholly beneficial (in addition to ministerial support and political will) in achieving that harmonious balance.

7.6.2 Changing Job Descriptions

> "Midwives provide safe, respectful, empowering, and equitable care irrespective of social context and setting and including wider reproductive health services."
> Standards of Proficiency NMC (2019)

The job of improving the 'Health of the Nation' (The title of the 1992 white paper report by the UK government as part of its strategy for overall health) has spiralled, it seems where the idea of Maternity still in crisis is a recurring theme. There is a sense in the data of midwives undertaking wider responsibilities than their 1967 counterparts: *"I do feel the role has got bigger"* says *Nancy (153-157),* and *"mushroomed" (Laura 20).* Working practices have also become more complex, *"More pressure! More paperwork!" (Nancy 153-157).* Antenatal screening, diagnostic testing, cannulation, prescribing, and ultrasonography feature as examples where midwives' capacity has widely become more involved in abortion. This medicalisation has detracted from the traditional scope of autonomous midwifery practice, in Betsy's opinion: *"I do believe that we are obstetric nurses at the moment…I feel like the art of midwifery is in its demise now" (Betsy 362-367).* This leaves midwives tied to a doctor. One cannot function without the other. Conscientious objection appears as an added *"constraint" (Betsy 367)* which creates *"that awkwardness when they're scrabbling around trying to find someone who can give them the care that they need" (Peter 80-86).* Documentation by two signatories and prescription of abortifacients are areas where administration is particularly difficult. Potentially a sticking point in the demarcation of roles, objection conflict contributes to CO crises. As an aspect to ethical decision-making, a more *"supportive" (Maria 124)* working environment could be one of the opportunities of objection.

Although the NMC Standards of Proficiency (2019) list “unintended pregnancy” and “abortion” in the midwives’ role in public health, health promotion and health protection (section 6.52.1), professional guidance is incomplete on conscientious objection. Participation is not specifically stated within the domain of “universal care for all women and newborn infants skills”. The lack of purposeful clarification about what comprises abortion care is perhaps contributing to the confusion about the scope and limitations of conscientious objection. The ambiguity may well be intentional, to leave sufficient room for compromise. Clarification about the intention of this statement would lead some way to accommodation to ensure,

“Midwives (truly) provide safe, respectful, empowering, and equitable care irrespective of social context and setting and including wider reproductive health services” (NMC 2019).

Participation in abortion is envisioned as a lifesaving, technical competence by the World Health Organisation (2022) with the potential to render preventable, every injury or death due to unsafe abortion. Family planning and comprehensive abortion care are part of primary health care, WHO maintain. On the release of the ‘*Family planning and comprehensive abortion care toolkit for the primary health care workforce’,* WHO assert *a*vailability of these services is critical for achieving universal health coverage.

“Health workers need the right skills - but also the right knowledge and attitudes”. (WHO 2022)

The International Confederation of Midwives, who outline the professional responsibility of the midwife, suggest an ethical balance,

“Midwives may decide not to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.” (ICM 2024)

This implies an Abortion Act specification, which incorporates a duty to refer, earlier discussed. Standard operation procedures to itemise participation is still elusive, however, precisely because of the varied nature of objection, presumably.

7.6.3 Managing CO since 1967

There are some concrete suggestions to come from discussions, which build on infrastructure already in place, but not all service changes are well evaluated. The PMA

role has implications in terms of knowing the team and endorsing freedom of conscience, yet this is not always portrayed in a positive light. As a gatekeeper of midwives' rights, the A-equip model of supervision, mentioned in data has been developed by NHS England and comprises of four distinct functions: clinical supervision, personal action for quality improvement, education and development and monitoring and evaluation (NHS England 2017). The Department of Health (DH) investigation led by Dr Bill Kirkup was critical of the additional tier of midwifery regulation provided by Statutory Supervision of Midwives. The Nursing and Midwifery Council (NMC) therefore commissioned the King's Fund to undertake an independent review of midwifery regulation. This resulted in a new model of midwifery clinical supervision from a statutory model of supervision to an employer led professional model called 'A-EQUIP'. This has implications for conscientious objectors and Catherine explains how: putting the answer to quandries in a PMA realm. The A-EQUIP Report (NHS England 2017: v) agrees that,

"The preparation of PMAs is crucial to the success of the PMA role,"

but it remains clear if this preparation does not encompass rights to CO and the transition to PMAs is not always well evaluated in the data. According to Gillman and Lloyd (2015), there are 3 main principles of the A-EQUIP model: 1) Consistent standards developed nationally, delivered locally with education and training; 2) Strategic response to national initiatives and strategies in the interests of quality and safety; 3) Integrated – employer led model incorporated into local governance arrangements. As an aspect of diversity, equality, and inclusivity, whether accommodation of conscientious objection is an acceptable or reasonable 'variation' remains to be metred out in the new model.

The importance of support for individual practitioners is well recognised in the interests of their well-being with implications for public safety and service consistency if they are not. In the data, again, dialogue is highlighted as an essential foundation for transparent, free expression of freedom of conscience. Karen (306-310) notes the infrastructure such as external investigators, *"some good things in Maternity – discussing cases, live cases"* that already function and the existing mechanisms for case review which distinguish midwifery apart from other specialities. Even building forums might help to convene on scenarios where duties, and obligations, rights and privileges are framed by accountability,

"(re: tribunals) Possibly, that would be a benefit. Whether they would be penalised by voicing their opinion or.... I'm not so sure." (Karen 158-259)

A tribunal system, as part of a conscience package, would remove the element of discipline in favour of democracy, legitimising freedom of thought, conscience, and expression in a non-threatening way. What Karen seems to be suggesting here is that tribunals could be used as a stick, rather than a staff or a scaffold to hold people to account. Both individual accountability and collective responsibility as a profession are both integral to the way society regulates midwives on behalf of society. In the interests of good governance, this is laid out in The Code, which expresses expectations of the knowledge, skill and attitude required. The Code, of course, is intended to protect, but also to support by giving midwives a clearer indication of their role. Although early declaration is widely advocated, because of its potential to straitjacket ethical decision-making, participants generally fall short of endorsing objector registration however,

“It’s hard, isn’t it? (Reflecting)....’Do you need to go on a register to say you are an objector?’ I don’t know…it could be transient as well.” (Nancy 222-226)

Catherine’s focus is on the silent majority. Still seeing the potential for developing the PMA role to be more receptive to objection theory and practice. She highlights the ‘unspokenness’ of freedom of conscience,

“One of the things that we should do is not focus on those who have got a voice or found a voice to object, but we should actually focus on those who feel that they can't at this moment.” (Catherine 329-331)

Francesca reiterates the importance of *“listening with an honest ear”* and “*honest conversations” (126)* when addressing sign-posting dilemmas. In terms of referral, practitioners may self-question ‘What should happen next?’ ‘Where do I send the patient from here and ‘Who do they see and speak to? If not me, then who will be the right person to send the patient to?’ along the abortion journey to,

“Have that honest conversation. So, I think it's right from the beginning, right up until the point at discharge.” (Francesca 125-127)

Here, Francesca is defining participation which the study shows means different things to different people. Like data, the scope and limits of CO feature in the literature (Dickens and Cook 2021) but the boundaries remain blurred in the findings of this research. Set against a backcloth of a medical dynamic, the law is only just catching up. Midwives interpretation of their participation is that it remains subject to change and adaptation, guidance is incomplete and understanding of how to access formal CO

pathways to reinforce employee rights wholly unsubstantial. If (as Gillian suggests), conscientious objection is an issue of recruitment and retention, then a more modern human resource solution is indicated: accommodation based on benefit to employees and employers alike, within organisations serving varied needs.

7.7 Model of CO Definition Explained

The Model of CO Definition originated in data analysis. At interview, the question 'What do you understand by the term conscientious objection?' elicited a range of responses as reflective starting points between researcher and participant. Responses were never quite set. In the sense and meaning making, characteristic of the Hermeneutic cycle, definitions were rendered more comprehensive and thoroughly rounded by later contributions of 'What do you understand by the term 'participation' in abortion?' Using IPA has enabled the emergence of an association between the two definitions. There are both similarities and sharp contrasts between participants which can be grouped to demonstrate analytical trends. Table 7.7.1 below details a 15-point prevalence/frequency table, which highlights the 'Model of CO Definition' which can then be applied to parallel definitions of participation. It shows which midwives adhere to no one quantifiable point and veer towards an explanation, highlighting their understanding of the objection concept.

IPA attempts to understand the meanings individuals attach to their human experience, as Noon (2018) suggests. However, it cannot be presumed that more significant experience is encountered by more people – not necessarily so – since IPA also measures depth as well as breadth of a phenomenon. In the prevalence debate in IPA, how to decide what 'counts' as a theme and what should be included in IPA data analysis is a source of uncompromising and polemic dispute (Gil-Rodriguez 2022). This is where 'The Model of CO Definition' meets with some agreement alongside the 'Spectrum of CO Views'. Thus, different perspectives are analysed in conjunction with strength of objection conviction and their range of belief.

7.7.1 Model of CO Definition

Model	Explanation/Rationale	Frequency/ Prevalence	Definitions Excerpt
Congruence	Based on understanding or perception, sometimes broad, sometimes, narrow. Knowledge or insight into the concept sometimes limited but objection voiced regardless of comprehension	Hannah Francesca Diane Ivy	"Not recently (come across it), no" (Hannah) "Got a basic grasp on it…. That's very much up to the midwife" (Francesca) "Depends what they're objecting to I suppose and how." (Diane) 'Not necessarily got a wide understanding of it' (Ivy)
Willingness/ Refusal-based	Declining treatment or not taking part – selective refusals on any grounds	Anna Laura Ivy Hannah	"Not taking part in something that you are not happy doing" (Anna) "I did actually refuse to do." (Hannah) "It means you could say, 'No-thank you', I don't want to work in that area" (Laura) 'You can decline to take part in that care' (Ivy)

Semantic Responses	Based on the emotional gut reaction to taking part in the act and how midwives feel about the act, having strong notions or personal thoughts. Highly interpretative and individualistic.	Anna Betsy Diane Francesca Karen	"Oh! Crikey…not being happy about doing something" (Anna) "Just their personal thoughts and very strong feelings about that" (Diane) "Because of your personal feeling about abortion….If you feel that strongly, you shouldn't be put in a position" (Francesca) "When you have a strong enough feeling to prevent you from taking part in somebody's care" (Karen)
Justification	Reasoning about causation and rationalising the reasons how and why people justify their objection; often a principled stance, one based on underlying pre-understandings and beliefs which in this model include the rationale of doing it because it is the midwife's job/role.	Maria Ivy Laura Peter Diane Jane	"Sort of, refuse to treat on the grounds of whatever beliefs…for whatever reasons" (Maria) "I don't want to be part of that because …" (Ivy) "Because it goes against my morals or my religious beliefs" (Laura) "Someone who on principle or moral grounds felt unable to participate in termination of pregnancy." (Peter) "Based on culture and background and religion and that's how they have come to that conclusion." (Diane)

			'On the grounds of their personal belief – it's based around themselves' (Jane)
Religiously Motivated	Theological in origin – not exclusively the remit of the R.C. church - although generally representative of a doctrine	Hannah Diane Laura Emma	"It is written" (Hannah) "Somebody has a theological or religious or cultural objection." (Diane) "Because it goes against my morals or my religious beliefs" (Laura) "Religion takes a part in it." (Emma)
Ideological Rationalisation	Interpretation can be cultural, based on beliefs, essentially subjective in nature in its moral reasoning and ethical decision-making - a sort of self-actualisation of the inner voice, often internalised.	Hannah Diane Jane Nancy Emma Francesca	"How they feel about abortion which I think, is not up to mem it's for them to decide that" (Hannah) "Just their personal thoughts about a particular ideology" (Diane) "Not believing in something" (Nancy) "I think it's personal reasons…how you were brought up…that's the main reason. It's their upbringing." (Emma) "Going against what you believe" (Francesca)

		Ivy Peter	“Moral, or ethical…you can have a strong belief without a religious belief – does that make sense?” (Ivy) “Someone who on principle or moral grounds felt unable to participate in termination of pregnancy.” (Peter)
Disagreement or Dislike	One to one conflicts and refusals based on any other characteristics – an impasse pitting the stance of service-user against HCP	Emma Francesca	“I could say I don’t really agree with it and decline” (Emma) ‘Well done for saying, “Actually, I'm going to hold my hand up and go. I can't do this.”’ (Francesca)
Experiential	A pre-understandings model, often developmental, based on one’s own lived experience of the phenomenon creating CO attitudes and opinions. Individualistic and highly personalised perspective based on what has happened to the objector	Diane Francesca	“Based on background” (Diane) “You yourself know about my personal history … and that I had a… you know, we lost a little boy at 32 weeks. And my family, in general, struggled with my ability to do my job. You know, they think that because of my personal life experience. They don't necessarily think that I could take that step back, and not think about me, when I'm seeing these women. You know, it was a little bit like, well, you, you've lost a baby - how is it that you could support these women to terminate a pregnancy? Because it can…because it's not about me … and that's very much how I feel about conscientious objection: to the midwives that feel strongly enough about this subject – “Well, that's great”. That's on you, you

			know, if you feel that strongly about this subject, and you feel the need to take a step back, that's fine, that's OK, because that's your human right." (Francesca)
Task-Orientated or Operational	Procedural aspects of participation – definition based on perfunctory roles and the midwives' contribution within the abortion process, sometimes pharmaceutical.	Ivy Diane	"If you've got a task or been asked to take part in something that you're involved with – a form of care, that you can decline." (Ivy) "About a particular treatment…they come to that conclusion" (Diane)
Organisational/ Locational	Depends on the setting or the way the service is operated	Diane	Diane's main focus is on transfer of patients to theatre
Legally Aware	Supporting the law and legal definitions of human rights used as a decision-making tool based on statute e.g., opt in / out based on informed consent. Given the highly personal, individualistic, and sometimes introverted nature of CO, solutions to CO dilemmas may well be difficult to legislate for and remain elusive.	Gillian Diane Nancy Emma Ivy	"Making an informed decision based on all the information that you have available" (Gillian) "How they came to that conclusion… working within the parameters of the law' (Diane) "As I understand it, in emergency situations, you would have to look after the lady legally. We have to look after the lady legally" (Emma)

			‘I couldn’t just walk out and say ‘ I don’t want to be part of this’. I would imagine that you would be accountable’ (Ivy)
Conscious Decision-Making	Actively balancing and weighing up pros/cons. The degree of doubt and uncertainty may be significant here. Facilitation may also depend on circumstances in assessing joint agency, options, and choices.	Nancy Laura	“Not believing in something” (Nancy) “You could say, ‘No, thank you – I don’t want to work in that area’’ (Laura)
Consequential	Thinking about the act’s impact (real or perceived)	Betsy	“What that does…” (Betsy)
Avoidance	A purposive reluctance to address the questions posed by CO	Catherine Francesca	“A touchpoint exercise rather than an in-depth conversation.” (Catherine) “Taking a step back from care provision” (Francesca)
Hybrid	Spectrum of objection, quasi-refusal, quasi-accommodation in a pragmatic way of viewing the process	Karen Maria Francesca	“Strong enough to…” (Karen); “Sort of…” (Laura) “‘So, I think it's right from the beginning, right up until the point at discharge.’ (Francesca)

Essentially the appreciation of what constitutes CO frames the entire discussion and how midwives express this comprehension differs. Views range from the theoretical to practical application and incorporate a plethora of different midwifery duties in which midwives do (participation) or don't (objection) partake. The two interrelate. The CO definition, forms a foundation on which to build, exploring ideas of accommodation. For all that some midwives state that their knowledge is limited, each then goes on to cite perfectly relevant scenarios, usefully poignant to the research and each articulates their standpoints. Knowledge or insight into the concept is sometimes limited but objection is voiced regardless of comprehension. In this highly circumspect comment, Diane highlights the individualised nature of CO,

"Depends on what they're objecting to I suppose and how." (Diane 153-154).

Generally, participants give us an invaluable insight to drive this point of the model: that where ideas are vague, better training on rights and responsibilities may prevent some of the worse sequalae of CO conflicts appearing in the courts and in healthcare settings. This logic is perhaps why employers, and the courts are reluctant to give up authority on the matter of CO: 'a slippery slope argument'.

7.8 A Slippery Slope Argument?

In critical thinking and rhetoric, this 'opening of the floodgates' relates to unintended consequences culminating from tentative first steps in a chain of (often negative) events. Criticised as fearmongering and a disproportionate or exaggerated response to relinquishing control, there are implications for objection management if its uptake is to be encouraged,

"Where we may end up recognising a right to disobey the law. I argue that there is a right to conscientious objection and that this may be justified through the notions of autonomy and integrity, which a liberal democracy should respect,"

states Ortiz-Millan (2017: 1). This thesis maintains the same position: namely that carefully regulated conscientious objection need not necessarily conflict with women's reproductive rights or be a threat to the (albeit precarious) status quo of abortion rights. There is potential for this to reduce the moral reasoning dilemmas experienced by midwives. It may yet be a requirement to be metred out – to which procedures, by whom and how objection is permissible, however. Accessing services could be rendered

streamlined without objection being a contention of exemption. Accommodation is not a boycott, it is a recognition, a realisation of rights.

Although essentially their views of ‘dishonourable disobedience’ may be opposite arguments, but on this point Fiala, Arthur and Ortiz-Millan do converge in that statutory intervention is required to redress imbalances at institutional, national, and international levels. Tongue (2022) explores a similar international human rights framework, urging states to adopt mandatory referral mechanisms where CO is permitted, often circumvented by professionals to “strike a contextual balance.” To this end, Catherine, and Karen both support the Abortion Act, believing in its adequacy for current requirements. It is *“good enough”* in Catherine’s words, precisely because it places the onus on the individual to declare the objection, rather than it being sought. They don’t go as far as Ortiz-Millan, however, in seeing the virtues of this as a statutory duty. There is a need for this, evidence from Laura suggests. Her comparisons of how referrals are handled in her experience, at worst and at best, illuminate the psychological distress caused to the patient and provider alike in the process when things don’t go well. The second scenario is more hopeful,

“Everything streamlined, and the systems were in place, so the ladies didn’t encounter any problems. They were dealt with quickly and compassionately and supported with the decisions that they made…. less of a hoop to go through.” (Laura 114-119)

In support of the findings of the literature review, data clarifies that understanding of the law is wholly incomplete and a challenge in changing workplaces. Thanks to Gillian, we know that staff are leaving the profession as a result. Strongly under-estimated in this ideological commitment and persuasiveness (Clarke 2019), this makes the law’s application, more real, already shown to be fraught with complexity (Maxwell et al. 2022; Fleming and Robb 2019; Chavkin et al. 2017; Regan and Glasier 2017; Will 2013). This is where the ‘Model of CO Definition’ helps – clarifying understanding, and reaffirming motivations - that whilst there may have been theological origins in CO (Toro-Flores 2017), there are more than religious reasons why people conscientiously object (Fleming et al. 2018; Czarnecki 2019). Examples of this now follow.

7.9 Illustration of the Model of CO Definition

Anna, Laura, Ivy and Hannah all focus on selective willingness to take part. Simply “*It means you could say, ‘No-thank you’, I don’t want to work in that area,”* says Laura (35-36).

Once the computing of objection has been semantically processed, it is possible to gauge objection more in terms of depth and range: a spectrum of CO which Fink et al. (2016) categorise as partial, moderate, and extreme, depending on to what degree participation is accepted. Definitions in this way, are notoriously problematic because of inherent difficulties around language, hence the model. The standpoints of participants are equally ambiguous – no one for example describes themselves as an objector – except in certain circumstances such as gestation. This is supported by the study, which shows conscientious objection is interpretative, polysemous and blends to the environment in which it is exercised (Minerva 2017; Dobrowolska et al. 2020). Like Romanis et al. (2020: 479) conclude, the resulting chameleon of policies remains "an eclectic mix" which a model helps structure.

In a secular society, when ideas about what it means to maintain a faith are changing, interestingly, rather more participants align themselves to an ideological rationalisation, as powerful, emotive, and controversial as Chavkin et al. (2017) would have us believe. In fact, Peter, too, takes pains to stress this twice, in e mail follow-up, post-interview, (for which ethical approval had been granted),

"Someone who on principle or moral grounds felt unable to participate in termination of pregnancy." (Peter 27-28)

Ideology can originate in culture, be based on generic beliefs and is essentially subjective in nature, just as moral reasoning and ethical decision-making can be. Although the RCOG (2011) may recognise the need for standardisation and closer definition of the deprivation of futures (Kuflik 2008; Nucci 2009; Marquis 1989; 2002), supervision and support for freedom of conscience decision-making is patchy. The literature shows that when care is contested, many assume participation decisions stem from religious or moral convictions (Menezes 2009), but beliefs may be much wider.

The conceptual model devised by Czarnecki et al. (2019) of moral work pays more attention to decision-making mechanisms which show conscience to be an emerging, iterative process influenced also by experience in social and institutional contexts. Whereas most research focuses on whether healthcare workers should be required to provide care that violates their conscience, Czarnecki et al.'s work explores how, which is equally complex. In conjunction with this seminal work therefore, our model and earlier moral reasoning framework, likewise apply theory to practice. In Czarnecki's work, distinctions around technical, material, temporal, and occupational aspects of participation demarcate a caregiver's role in an abortion: a response to criticisms that

existing frameworks for understanding conscience do not capture the everyday experiences of healthcare workers. These frameworks assume that caregivers fully know their views on abortion participation prior to immersion in a setting where abortion is offered. Like in the model of CO definition, in the Czarnecki's research, respondents held different definitions of participation and participation was not a straightforward binary "yes" or "no" decision. Calling attention to work experiences, contexts, and abortion as a process involving various actors and tasks, the day-to-day realities of abortion work not only proved critical for how respondents' thought about and made participation decisions, but also challenged our very conceptions of what constitutes "participation." This study agrees. Where it addresses limitations of Czarnecki's work is in adding a reflective framework specific to practice that is easy for practitioners to apply which meets gaps in the existing conceptualisation of 'moral work'. Although some years before, Czarnecki's conclusions align with Dewey's theory of connected experience: (how what we do links to our own experience) itself a reflection of Consequentialism.

An 'ideological model' is a sort of self-actualisation of the inner voice, often philosophically internalised. Above all, an ideological model demonstrates that, regardless of religion, conscientious objection may well be conscience-based or concerned with the spiritual.

"Just their personal thoughts about a particular ideology" (Diane 16)

"Moral, or ethical…you can have a strong belief without a religious belief – does that make sense?" (Ivy 24-25)

The practicalities of participation are more closely inspected in the 'task-orientated or operational model'. Presumably, because of the elusive nature of participation, described regularly as "a grey matter", this model above all others has relevance to the day-to-day dealings of CO in practice. Some midwives seem to define the tasks inconclusively and are ambiguous about what participation means. The minutiae often lack clarification. Midwives in the study are as confused about procedural aspects of participation as the literature reflects. "Care" is a broad term, perhaps better described as an attitude, more so, what care can be withdrawn from, so this is hardly surprising.

"If you've got a task or been asked to take part in something that you're involved with – a form of care, that you can decline." (Ivy 24-25)

Maxwell et al. (2022) in a recent paper thematically analysed semi-structured interviews with 17 midwives using a human rights framework. The extent of limitations of current provision for exercising their legal right was reflected in the four themes which are mirrored in this study: respecting and protecting; making informed choices; providing non-discriminatory care; experience and culture. Like this study, Maxwell et al. (2022: 1) concluded,

“There was an overriding sense of support for midwives to be able to exercise their rights to CO, how this is operationalised in practice, however, continues to be fraught with complexity.”

Recommendations build on these findings, echoing calls for a “much-needed” national picture of how CO can be accommodated, the challenge of finding a balance. Given the complexities, midwives seem to therefore turn to location to conceptualise where CO occurs, rather than what it comprises. Some mention theatres, others, emergencies, the ward environment or G.P. surgeries, familiar to the midwives’ consciousness. This helps to situate the scenarios, per location, and gives a sense of organisation as the service-user travels along the abortion journey. In McLemore et al.’s (2015) study of nurses’ decision-making, this also proved to be the case: authors found that treatment urgency, the type of clinical setting and whether the procedure was by a designated provider shaped how nurses navigated tensions (criteria specified in the Abortion Act). In this study, similar concerns reflected in incidental findings around telemedicine (Karen, Nancy, Peter) and there is much discussion on the cross-over between Maternity and Gynaecological services.

As stated, part of the CO quandary is in its lack of clarification in law (Will 2013). In a ‘legally aware model’, therefore, midwives’ are keen to support the law, providing legal CO definitions that include issues of human rights used as a decision-making tool. For Gillian, the opt in/opt out is based on all parties freely having access to information, a pre-requisite to ethical decision-making and for her colleague, Diane,

“How they came to that conclusion… working within the parameters of the law.’ (Diane 263-264)

Nowhere is this more apparent than in CO crises, where clinical emergencies become more complex because of the moral distress caused.

“As I understand it, in emergency situations, you would have to look after the lady legally. We have to look after the lady legally” (Emma 22-23)

‘’I couldn’t just walk out and say ‘I don’t want to be part of this’. I would imagine that you would be accountable.” (Ivy 25-27)

‘Conscious decision-making’, involves midwives actively balancing and weighing up pros/cons. The degree of doubt and uncertainty may be significant here. Facilitation may also depend on circumstances in assessing joint agency, options, and choices.

The effects or impact of CO, potential or real, feature more in the ‘consequential model’. ‘What if?’ scenarios or dilemmas of ‘If not me, then who? If not now, then when?’ which appear in the data, emerge in early CO definitions. This ‘What will happen, if I don’t act?’ ethos is powerfully and poignantly expressed by Hannah,

“If someone bled like anything, how would it really end? … What will happen if it is stopped by the NHS?” (Hannah 63-68)

Francesca’s idea of what happens in CO is one of avoidance,

“Taking a step back from care provision” (Francesca 39).

Let us now turn our minds to the original point of the model – that definitions of CO are an integral component of how midwives perceive participation (then presumably, what they do to act out CO according to those beliefs). In the latter part of the model, which concentrates on ‘participation’, there seems to be a lack of clarification around terminology, apparent in the following statements,

‘It could be anything, really. An objection to that they … they don't want.’ (Diane 17)

‘Probably just a basic understanding…I’ve never really thought of it in much depth.’ (Jane 98)

The contentious nature of abortive acts combined with lacking precision over how to define participation represent the main gaps in knowledge which this thesis aims to address. In fact, in the Scottish case of Greater Glasgow Health Board (Appellant) versus Doogan and Woods (Respondents) (detailed in the literature review), Lady Hale adjudicating, recognised the “moral repugnance felt by many people to terminating pregnancy”. Her characterisation of the reversal brought before the Supreme Court on

17th December 2014 placed the issue firmly on the grounds of statutory construction. The decision was based squarely on the language of the statute, of which the court adopted a precise and tailored reading. Calling for closer legal definition of the term participation and its meaning, Lady Hale stated,

“It will immediately be apparent that the question in this case and the only question, is the meaning of the words “to participate in any treatment authorised by this Act to which he has a CO.”

In this regard, IPA has particular credence and the contribution of models of definition may prove invaluable in forging the way forward.

The same phrase was considered in the legal case of Janaway R. versus Salford Health Authority (1989), a G.P. receptionist who unsuccessfully objected to typing a latter referring a patient to a Consultant for a possible termination of pregnancy. The House of Lords decided that treatment meant,

“The process of treatment in hospital for the termination of pregnancy,” and that participation equates with “actually taking part in the process”.

The case highlights that in gaining an appreciation of CO, and its legal endorsement, it is helpful to understand what CO is not. Catherine expresses similar sentiments,

“The opposite, the opposite of participation, also for me – what participation isn’t….is if you were a nurse on a ward, or a midwife on a ward and the lady, the family were not in your care. Then that wouldn’t be participation. So, if you were on a ward…uhm and not asked to be part of something. It’s a care provision, then you’re not participating, so that would be for me a clear definition.” (Catherine 132-136)

In considering what CO may not be, Catherine thus drives her point: that accommodation of CO rights is worthy of facilitation – with limitations. That in life-threatening clinical decisions, the primacy of the service-user supersedes the individual’s moral integrity is not in dispute, but greater recognition is needed that,

“*Midwives probably compromise their own standards or their own beliefs or their own ethics….at the bottom of the heap is what the midwife wants, or believes or feels comfortable with…” (Catherine 182-187)*

As such, there is more heavy reliance on other aspects of the model. For example, in the willingness/refusals-based sub-section, Diane again gives forth a broad definition, like that rendered previously,

"Any part of that care, you know? That you could do."

Semantics again appear in Catherine's understanding of participation, as emotional support of women as part of direct caregiver role, but the broadest definition of participation is perhaps Jane's,

"Involved and supporting an individual, not necessarily the one for example administering the potassium." (Jane 94).

Not without contention, like Peter's justification-centred definition of participation,

"'Every other element is up for debate.' (Peter 173),

the most ambiguous definition of participation belongs to Nancy,

"'erm care-wise, I suppose we see more termination due to fetal abnormality at a later gestation as opposed to our role, we don't see the earlier gestations, say up to 12 weeks. You know? I suppose it would be participating in any care, I suppose.' (Nancy 48-49)

As you would expect from a midwife of Catherine's seniority, her definition of participation appears wholly more accurate – apportioned to a task-orientated and procedural model,

'It's a direct care giver role. So, anyone who had to advise on termination, anybody who had to participate in the procedure and that could be administration of medicines, right through just to take and monitor observations.' (Catherine 124-126)

Inevitably, in such an unclear, dynamic subject, overlaps are inevitable. Notably, one size does not fit all in the model which goes to show midwives can adhere to more than one perspective or that these can change over time. Definitions can uncategorizably appear in more than one of the fifteen sub-sections, but this is not to decry its usefulness as a framework to scaffold the debate. A better understanding of participants' thinking on objection ensures it becomes more situated and grounded, reflective, and Hermeneutic. The sense and meaning making of recommendations will then prove

ultimately data driven. Perhaps therefore finally, a more pragmatic approach is called for – and this is what the 'hybrid' model of CO definition miscellaneously tries to achieve. The most comprehensive definition, thus, if proffered by Francesca, in a chronological timeline,

'So, I think it's right from the beginning, right up until the point at discharge.' (Francesca 126-127)

7.10 Gender Considerations in the Data

In the data, all participants agree that abortion is a feminist issue, and this correlates with midwives' moral reasoning around freedom of conscience. Participants support the woman's right above all others' to bodily autonomy, superseding any feelings of dilemma, but it is not without doubt,

"I would say so, more women's rights, yeah. More women's rights, because women should have a choice with what they do with their own bodies," states *Emma (210-216).*

This woman-centredness helps us understand the majority position, as participants justify their overall support for a legal, safe service as a sexual and reproductive right. Overall participants defend abortion with limitations; their endorsement of objection is conditional. They voice a tolerance of dissenting colleagues with views that are different so long as opinions do not impact negatively on the clientele. Regardless of whether participants themselves practise a religion or have views on freedom of conscience, they do not object in practice. That is not to say that participants do not express a lived experience of ethical dilemmas, and many have metamorphosed in their CO thinking mostly related to working in women's health or due to personal experience. Nancy goes one step further, however, arguing that questions raised around abortion affect everyone, transcending gender,

"I think it's everybody's issue. I think it needs to be discussed more but it's not necessarily a feminist issue. I don't know, although I do think I am a feminist. I think it's an issue for everybody….My uterus! My choice! That's what they say. ...it's her uterus, at the end of the day. That's a really difficult one. My husband would say, 'no'. He is very much, 'That's that woman's body, that's her choice', I do feel the same about that, yeah. It's the woman's choice." Nancy (373-383)

In effect, executing the procedure to realising the wishes of the woman involves ethical decision-making amongst practitioners, but third-party rights do not exist in law, however,

"At the end of the day, it's the woman who's going through that. It's that woman who's putting her life at risk, isn't it?" Nancy (385-387)

As regards access rights, and the potential effect CO have impacting these, all participants tend to adhere to Peter's view: that the midwife's participatory role is one of advocate and facilitator,

"I think it's personal choice and my position is that it's not for me to decide what people should and shouldn't do with their bodies. As a midwife, that's at the core of what I do. It's facilitating bodily autonomy. As difficult as I find it (because I don't find it easy), it's for me to make those decisions- that I will support people as best I can. I don't know what has brought people to those decisions where it's almost not my business. I just have to be professional and supportive." (Peter 117-121)

Participants conjuncture about paternity rights at various points,

"*I think it would be difficult for a man to...if he felt that strongly about pregnancy, that would be awful! If he really did want it, that is." (Nancy 383-385),*

but this discussion is largely speculative and hypothetical. In Anna's words, as responsibility for childbearing and childrearing remains predominantly with the mother, her wishes ought to take precedence,

"It's all to do with, the fact that ok, when a man can get a woman pregnant, but It's the woman who has to carry the baby, look after the baby. When a baby is born, when It's older. It's a lifetime commitment, for her. And if she feels that that's not right time in her life for her, to do that, then I feel that that's her decision. Especially when you're thinking about it could be because of rape, or abuse, when It's been very difficult for her." (Anna 73-77)

Of course, the position of women within families and in contemporary society supports a much wider and more complex role than childcare. Access to safe abortion is part of the package controlling reproductive choice. It enables fulfilment of these expectations which realise bodily autonomy. Betsy does not deny how conflicted both parents can be by the abortion decision, however. She agrees that responsibility for what happens with

the pregnancy, a consequence of unprotected sex by two people, should be a joint decision,

"I tried to see it from a male role is that you know if it was my son or if it was my father or if it was somebody that I love dearly, and they were going through this and they didn't want somebody to terminate. It's still until we have a society where men are made to be responsible for, so equally responsible, for what happens when that baby or that child is born then. Wait, no, I don't think they should. When we look at the society that we're in and men can reproduce and then say I'm going to walk, walk away from that and never, never have to care for it (that's not me saying that that's what men, all men, do and always the way all men behave). But until they are made to, you know, until they have the same, the same responsibilities and the same, and it has the same impact on your body. It's never going to happen, but that's never. That's never the way it's going to be. So it should be, it should be a woman. They also have a right? So, to you know. Make sure that they don't impregnate somebody like that." (Betsy 475-487)

As far as freedom of conscience is an issue of empowerment for the marginalised or oppressed (Price 2011), reproductive justice includes provision for those who may not identify in traditional male/female roles. Further consideration and representation for the inclusive rights of diverse groups will now take place, by looking at the lived experience of ethical dilemmas amongst male midwives.

7.11 An Alternative Perspective of Conscientious Objection

The Finnish study, (Nieminen, Lappalainan and Mustonen (2015), conducted among medical/nursing students and professionals, is one of the few papers which addresses the respondent's sex. Male respondents were more tolerant of later gestation abortion. 3.5-14.1% of all respondents expressed a personal wish to conscientiously object. Freedom of conscience was more common among midwives and half of all respondents considered that *any* conviction (other than religious) would be sufficient. This provides us with useful insight into overall trends. It enables us to make few generalisable conclusions however from comparisons both between:

- sexes (who bear the responsibility of childbearing and child reading differently)
- professionals (increasingly but not predominantly male)
- countries (where gender bias maybe part of everyday life for millions of people)
- members of the multi – disciplinary team (where questions are raised that may reflect male/female stereotypes and power struggles)

- religious observance (which may vary according to gender)

Conscientious objection is a matter that poses ethical dilemmas wider than those mentioned when conceptualised in terms of the midwife's own biology,

"I'll never be in a position where I have to make those decisions and that's quite a privileged position to be in. So, I can't. I feel that it wouldn't be acceptable for me to have a conscientious objection, really, how could I justify that, having been admitted to the profession? As a man, how can I turn around and say, 'Actually, I think this is wrong,' you know, it feels an untenable position." Peter (121-125)

Peter notes the embodied conflicts from a perspective of being in a minority (here described as a kind of affiliation, 'us'), a practising male midwife,

"Yet I feel there is a conflict there – it is an exclusively female profession, bar a handful of us, so there is a risk that if I come in...and being very visible as a man, say, 'I object', everyone scrutinises what you do…it would become absolutely the talk of the town. It would become part of the debate about 'Who's he to make those decisions? Who's he to say these things? We have let him into the profession and there he is telling us what we can do with our bodies.' Maybe it's entire conjecture, on my part, but these are the thought processes that go through my head because, I know, everything I do is much more visible and open to scrutiny than if my colleagues did." (Peter 128-137)

Peter's comments show how professional values, (such as equity, non-discrimination, justice and fairness), enshrined in law and aspired to in practice are not truly being recognised. Intimidation mentions pressures on professionals not to voice or act out freedom of conscience, which after all, are universal rights accrued regardless of how one identifies one's sexuality. Conscientious objection is akin to the preservation of basic human rights as real between colleagues as between service-user and service-provider. The manifestation of their expression is a great deal more than stated.

"If you have a difficult delivery and maybe you don't manage it as well as you could have done, (I see that all the time with my colleagues) but if it happens to me – then it becomes a thing. So, you get a bit of a reputation, so you have to be on your guard the whole time. I feel like that in the situation where they said, 'Can you go into room 10? There's a woman who's come in for termination for, say, fetal abnormality', and I say, 'Actually I don't really feel comfortable with that,' I could just see the tumbleweed as

everyone would just stop and kind of look and go, 'Wow!'. Does that make sense?" (Peter (128-143).

In the event, Peter maintains support for abortion but says the reality of participation, carrying out the procedure is another, separate, lived experience which is "*bracketed and put to one side",*

"Does carry an emotional cost. It's not something I did lightly, or unthinkingly. It was not something that was nothing to me, but I felt like, I couldn't be a midwife, I couldn't be a man and a midwife if I wasn't going to support fully women's bodily autonomy and that extends to all realms of it. What I think personally, you know? (Shrugs) Let's just bracket that and put it to one side. The reality is, I didn't know what I thought. I thought I knew what I thought, until I had to do it – then it becomes a very different thing." Peter (408-412)

Interestingly, he differentiates between belief and action, manifesting those beliefs here. Although midwifery is a predominantly female profession, the masculine bias is worthy of note, that inevitably leads to friction when effecting infrastructural change. Peter observes,

"It's a very male way of looking at it, so to take that Audre Lorde quote – 'You won't rebuild the master's house, using the master's tools'. We can create all of these policies, but it still sites within this medically orientated, patriarchal, male way of looking at healthcare provision." Peter (527-529)

The resilience of male constructed philosophy and healthcare policy that upholds those patriarchal values is perhaps what Peter alludes to here in this quote. In the most empowering sense, therefore, we get a sense of what feminist ethicists can contribute to moral philosophy for those subordinated by and within social hierarchies.

7.12 Spectrum of CO Views

That midwives for the main part, maintain the middle ground means attitudes to participation are mostly moderate. According to Aristotelian theory, the 'conception of the mean' is an ethical way of moral reasoning, in itself (Cantens 2019). How good, practical and rational calculations require considering the content around the moral event, calls for some degree of 'attitude modification' which guards against vices,

“The principle of the mean states that virtuous actions are somewhere between the two extremes of a given kind of behaviour.” (Cantens 2019: 150)

Whether act centred (relating to participation in the act of abortion) or agent-centred (reflecting the part played by the participant), aspects of Aristotelian thinking may prove helpful in understanding CO perspectives. Practitioners may ‘do good’ or inflict ‘harm’ in the quest for eudaimonia, whilst applying pleasure/pain principles.

In data, objectors are respected for a differing position to their own, but this is mostly conditional – depending on the impact on the service and moreover still, the service-user. So stark in midwives’ moral imagination are recollections of backstreet abortion, that almost all midwives comply with the current status quo, hypothesising that there is no other feasible alternative than the current fully endorsed service. Above all else, they support safety, putting this before concerns about midwives’ moral distress. Just as ethical principles are ranked, doing no harm is prioritised. It is not always clearly identifiable, what the good might be in abortion, however, and who are the main beneficiaries. Whilst common sense prevails, and all support that risks to life should be minimised, there remains still an uneasy balance between stakeholders, whose interests may be incongruent. The challenges of walking that tightrope are impressed in the readers’ minds. Juggling questions like when does life start? definitions of personhood (Chervenak and McCullogh 2003) and arguments surrounding potentiality make the midwife’s extended role more complex than ever before. In the austere Maternity environments in which midwives practice, there is a realisation that overall, advances in medical science may boast significant achievements but not be a panacea for all ills. New ethical problems have been created in bringing life. In doing good, still there are winners and losers. Ancient dilemmas are resurfacing, as the boundaries of CO are stretched alongside redefinitions of human life and its age of viability. Never before have midwives been so vocal and politicised about the lacking attention paid to their rights. Societal assumptions around their professional obligations are being challenged.

Although the need for its “*tweaking”* is recognised, even those midwives who are reasonably well informed about the Abortion Act and its critique, do not necessarily come up with any other solution to address its flaws and weaknesses. Given the current climate, timing is widely assumed to be opportune. Over fifty years since formalised in statute by the 1967 Abortion Act, whether freedom of conscience is truly being realised is debated in the changing scope of participation.

The analytical framework - a ‘Spectrum of CO Views’ – ranks the responses of all participants in order according to the strength of CO conviction (see Appendix 10). The Model of Definition (section 7.7 to 7.9) discussed the kaleidoscope that is freedom of conscience – originating in a number of disciplines, manifesting in different ways, multi-factoral in cause and definition. How these varied beliefs materialise is also incorporated in the ‘Spectrum of CO Views’. The order was mostly determined by the participatory activity of the midwives, task driven, admittedly. Another criterion used to rank how midwives reflect on their experience, is how they rationalise and make moral judgment on other objectors’ actions. Their expression of this ethical decision-making is part of the IPA-ness of the study – their sense and meaning making, wholly qualitative.

Most pro-actively pro-choice is Peter at the right of the scale, not only on the basis of semantics - because they feels that an objector position is 'untenable', but because they has participated in abortion procedures widely. The most ardent supporter of an incompatibility thesis is Laura,

“Well, in my head, to me participation in abortion is all of the things. So, for me, I have participated right at the start of the process, to get them referred for it to be done, I have organised the meds for the women to start taking the mifepristone, I have participated in that way…. then at the other end I have participated in theatre whilst it’s being done. So, I suppose I have been party to all acts of participating, erm, apart from doing it myself.” (Laura 199-203)

She is graded here less supportive of objection, because of her active participation, a broad definition in a task-orientated model. Despite tolerant views on accommodation, her standpoint does seem rights-aware, making referrals, ordering pharmaceutical products, and conducting feticide. With her insight into antenatal diagnostic screening, Ivy's position is still rather far right in favour of service-user choice. But again, she still maintains a middle-ground in appreciation of colleagues who may have differing views to her own. Looking at the macro view, all participants' location is central (indicating moderate views, in the middle ground with openness to accommodation) or right of centre (predominantly abortion-defenders) but this is conditional. Interestingly, not one participant described themselves as either anti-abortion or an objector, including even those with religious upbringings who sometimes differentiate between what they would accept in a patient and for themselves (Maria and Nancy). Participants with a religious upbringing, comment on their views having changed, like Diane, Maria, and Nancy,

which highlights the complexity of looking at causal relationships and how subjective is the lived experience.

Useful insight is afforded into dilemmas when covering standpoints. In being asked the question – 'How would you describe your position?' a lot of participants said, ...'this, that, except, but or however'. In exploring what a lot had previously never really thought about (Anna and Jane), or vocalised to the point of actioning objection (Gillian, Nancy), we gain still a sense of the lived experience of ethical dilemmas presenting in CO. The situational analysis goes to supports the premise of the thesis - that accommodation can facilitate objection as a worthwhile and valued concept, but support is *with limitations.*

7.13 The Unique Contribution of this Work

Accommodation need not infringe reproductive rights. Conscientious objection theory just recognises practitioners have rights, too. In this regard, some ideas expressed in the thesis are not new. Instead, the thesis builds on work by earlier commentators, like Wicclair. It holds the same premise, but in respect of midwives. In being UK based, conducted in the shadow cast by the Abortion Act, this rethink of conscientious objection comes at a time when a medical model is fast declining (doctor-led, diagnostically driven and hospital orientated). The study epitomises midwives' developing autonomy and extended responsibilities in roles never before quite so participatory. Participants express views set mostly within the NHS but also in conjunction with private providers. In post-1967 configured services, the questions asked in this study are against a fluid background, in a global context within changing parameters of sexual and reproductive health and a multi-dimensional abortion provision. The pandemic makes this study's unique contribution even more highly tuned.

The chasm between personal identity and public space is examined by contemporaries. Understanding of ancient concepts, like conscience, is enhanced. In the thesis, landmarks in moral reasoning are termed here 'CO crises'. This throws light on 'mentally traumatising' lived experience, the dilemmas associated with ethical decision-making and the situations which give rise to them. The rapid assessment tools reflect thinking already employed in midwifery practice but offer a more evidence-based approach to frame the problem and address inconsistencies.

In this regard, IPA methodology makes a unique contribution, as it is expounded to do so well, in emotionally laden subjects. The body corpus of literature in the field, demonstrates a new departure is called for. Using the participants' lens is a unique

opportunity at a key time because of the historicity, to explore how a given person makes sense and gives meaning to a given situation in given scenarios. Findings are interpreted in a novel, ground-breaking study, expressed in uniquely creative themes. The most original of these considers concepts related to the neonate and dilemmas related to resuscitation. This is not witnessed elsewhere so represents a new conscientious objection perspective, a gap in the body of knowledge.

The products of the thesis – the 'Framework of Moral Reasoning' and the 'Model of CO Definition - remain the biggest and most unique contributions. Both support and recommend well governanced and consistent practice, which build on guidance already available. One is aimed at the clinical area, the other a conceptual tool that contributes to conscientious objection theory. Although designed by professional bodies, current provision is considered to have certain drawbacks of which midwives are mindful. In calling for a charter of CO rights and policy at organisational level, the recommendations take the debate one step forward.

7.14 Aims and Objectives Revisited

Aims and objectives will now be examined consecutively in the manner of revisiting those set out to accomplish. It will identify how each gap in knowledge has been addressed and outline how each objective has been achieved. Basically, this section tackles the extent to which the thesis measures what it was intended to, a discourse about quality.

1. To make sense of midwives making ethical sense of conscientious objection as a clinical process

Midwives were recruited purposively from a broad range of cultural and ethnic backgrounds, religious persuasions, age groups and sexual orientations. Many expressed similar reasons and motivations for becoming midwifery professionals but reflected on differing points in their career at which they had encountered CO. Their experience within Maternity, however, did not necessarily match their lived experience of abortion – related ethical dilemmas. Encapsulated in the thesis' concept of CO crises, midwives' actual participation within the perfunctory aspects of the abortion process ranged extensively – some had, and some had not partaken in the procedure - but this did not matter as the focus was on the process midwives went through to establish their position. This brings homogeneity to a multi-faceted subject which considers these midwives own unique perspectives. How any non-involvement impacts on care, rather

than originates, was the focus of the discussion. The aim and objectives were transfigured to reflect this, mutating, and transforming in a typical Double Hermeneutic fashion, as recommended by Smith, Flowers and Larkin (2022).

The rich data gleaned at interview showed all participants had machinated through moral mechanisms to arrive at very eclectic outlooks. That some of the clinical processes followed the modelling of quick and slow thinking was interesting, especially given that every conscientious objection decision may be different depending on the degree of emergency.

Together with literature reviewed, midwives' logic and rationale formed the basis of a framework of moral reasoning designed to learn from the insight provided into the lived experience, now thanks to this thesis, interpreted, conceptualised and formalised.

2. **To identify what is the lived experience of moral reasoning and decision-making for midwives when required in employment to partake in abortion procedures**

The framework gives credence to how midwives reflect on ethical dilemmas. It provides an evidence base to structure thinking, individually/introspectively or within professional groups. As such, the framework can be applied as a tool, for example. thereby avoiding inconsistencies and inequities which make some objections contentious, controversial, unethical, and notoriously unfair. Formalising objection in practice reinforces professional commitments to midwives' rights on freedom of conscience, ensuring its application is mindful of safety and legality amongst employers and employees alike. The framework can be used case-by-case, midwife-by-midwife, for each CO crisis, decision-by-decision in the journey, a continuum running parallel alongside the service-users'. Since the objective centred on 'midwives when required in employment to partake in abortion procedures', the limitations, and boundaries of their personal values, were touched upon but predominantly compartmentalised. Their coping mechanisms were offered forth to take forward the impasse of contradictions – practising midwives, practising religion, or navigating with a moral compass - who reach out to other colleagues. The Model of CO Definition echoes that.

Formalising CO ideas reinforces understanding of midwives' rights to freedom of conscience, ensuring its theoretical, theological and philosophical origins are recognised and respected with due weight and appropriate reverence. Ethical dictums on the 'rights of persons' are integral to mindfulness about moral well being, psychological safety and

resilience amongst employees. That so many policy recommendations mention this show that employers, the midwifery profession, the team, and society at large have a lot to gain also.

The model can be used case-by-case, midwife-by-midwife, for each CO crisis, decision-by-decision in the journey, a continuum running parallel alongside the service-users'. The thesis' model works hand in hand with the spectrum of views – which illustrates the variety, depth of conviction and their complexity of CO beliefs. Mostly midwives approved of the current legal provision as 'good enough' to protect them. Although increasingly medical science had its challenges, they believed, the current law enabled them to carry out their duty of care with due regard for their role as defenders of public safety and advocates for individual bodily autonomy.

3. To explore midwives' ideas for improved practice in relation to what constitutes participation in the abortion process

Outside of the Charter of Objectors' Rights (an innovation unique to this study) most of the problem-solving ideas for improved practice represented a re-examination of solutions featured in the literature reviewed – tribunals, registration, and a supportive colleague network, for instance. But there was a more current reflection. Certain suggestions, such as table-top discussions and PMA gatekeeping, show how valid a rethink on CO is amidst the dynamics of healthcare reform (especially in a pandemic). The confusion around the process of telemedicine, disordered understanding of midwives' rights and muddled definitions of what participation comprises all confirm the relevance of the study. The potential for enacting its recommendations could have positive impact in terms of raising awareness, re-evaluated as shown.

4. To disseminate findings to ensure ways to accommodate CO whilst providing abortion services as part of accessible, legal, and equitable healthcare

Regardless of their beliefs, it was reassuring that all participants supported safety – they did not support conscientious objection at all costs by any party like a blank cheque. True to their profession and the values it upholds en masse, there was keen attention to ethical practice, promoting prima non nocre, or doing no harm, above all else. To varying degrees, participating midwives felt akin to Egalitarian principles, and expressed their passion for the prioritisation of patient need, and the primacy of patient well-being.

The iterative IPA techniques for eliciting idiographic responses ensured that. The recommendations reflect that, too.

That is not to say the midwives in this study expressed an intolerance of human rights or repugnance to conscientious objection. They were sensitive to the win:win situation and the logic of well-proportioned accommodation of rights. All maintained discordant and hostile relations benefit no-one. They advocated a tuned in and sophisticated system for achieving this including 'tearoom conversation'.

7.15 Discussion Conclusion

It has been shown that the nature of CO is a transient, developmental, and interpretative concept, yet one that is central to personal identity. Being so ubiquitous, solutions to the issues it raises are difficult to pin down. IPA has much to contribute to the understanding of conscience dilemmas, encountered as the professional accompanies service-users' abortion journey, through landmarks that are termed here 'CO crises'. A very phenomenological view of CO, like Heidegger's 'In Being and Time', IPA helps to provide a glimpse of moral reasoning to illuminate the lived experience. What is essentially an inward-looking psychological process is now given an opportunity to voice, to speak out on ethical dilemmas in respect of CO and abortion access, so tacit, implied a subject, riddled with taboos. Skills of impromptu, rapid assessment often reflect those similarly employed in midwifery practice, but CO crises do not rest on urgent clinical need alone. It has been shown that in reproductive health, because of the time-bound nature of pregnancy, dealing with two lives, dilemmas are more ardent. The midwife may feel torn, caught in an impasse, trying to balance a plethora of interests in which her position may have less influence on the gravitas of the decision-making. In addition to public safety, sharing these decisions shares the conscience burden. It guards against misguided judgment, Paternalism, and misconduct, from which everyone can benefit. Indeed, whatever your political persuasion or abortion perspective, an accessible, transparent, non-discriminatory service is surely preferable to pre-1967 conditions: which like placard-waving, is not the point of the thesis. It supports frameworks of good practice, but the guidance available designed by professional bodies does have certain drawbacks which midwives are mindful of. The tricky situations emerging in the data demonstrate that disagreements and conflicts do occur, pitting professionals against each other and much worse, against patients, impacting on care. Delays, distress, and inconsistency are detrimental to a streamlined, smooth-running abortion service – a legal service, after all, endorsed by statute. For those passionate about defending reproductive rights over when and how many children to bear, there is

no evidence that in the current UK situation, that principles of patient-centredness are not being adhered to. Midwives acknowledge the achievements of medical science in keeping with the values of the NHS constitution but there is a sense of this not being a panacea for all ills. The compassion of midwives is clear. In providing care for often the most vulnerable in society, themselves in crisis, means that the system for dealing with unwanted pregnancy relies heavily on the subversion of their moral principles: principles that are worthy of defending; principles, that support conscience, principles that are an integral part of healthcare. Accommodation need not infringe reproductive rights, it just recognises midwives have rights, too.

The midwife's role remains one of communicator, facilitator, educator, advocate. Even in pregnancy loss, there exist opportunities for empowerment. Rethinking Egalitarian respect for autonomy and moral agency, accommodation resifts that balance of power – to become more harmonious.

In the discussion, the six GETs take a multi-faceted look at all beneficiaries, taking into consideration the pregnant service-user and their wishes, the status of the fetus and controversies between rights to life as well as on the flipside, the perspective of midwifery practitioners, equally torn. That 'practising midwife, practising religion' forms the title of the first theme pays due homage to CO's theological origins. A deontological feel pervades in scriptural citations bringing to the data, divine questions of 'playing God?'. Is there a fateful game of chance in which certain practitioners play the CO 'ace' card in the name of protecting 'the innocent'?

However, conscience-based, ideologically motivated foundations are not to be overlooked. Navigating the abortion journey employs a 'moral compass' in decision-making which all for balancing choices, weighing up pros and cons. The application of ethical principles, in this study, appears mostly Virtues-based which seems to be what the midwives are most familiar and conversant with. Other rationalisations are touched upon, which a framework builds upon.

Achieving best outcomes for the pregnancy whilst predicting the newborn's future is a fine tightrope traversed by midwives precariously. Drawing upon arguments of potentiality, closely linked to gestational ages of viability (much more than legal definitions at 24 weeks), the GET 'fearing reviving, surviving and thriving' looks at whether moral reasoning about whether the baby will live and be healthy and relates to caution about dilemmas if the baby is born with signs of life.

Midwives often compartmentalise their feelings as an emotionally intelligent strategy for coping resiliently with dilemmas mostly born of conflict between their personal circumstances, beliefs and professional obligations encountered in the course of their employment. Although not necessarily voicing an objection per se, midwives often suppress doubt and uncertainties. Anything other than their endorsement in support of a legally provided, societally approved abortion service is treated as a disobedient dissent but in accommodation, there are feasible alternatives. We have examined how in the GET 'two signatories and the escape clause', there are legal aspects to consider in the changing context of abortion and how provisos made in 1967 may have become outdated. Widely viewed now as engendered, better suited to a Victorian age and irrelevant to modern needs, The Act's flaws urge a rethink. Although midwives express overall support for the Abortion Act, its practical details are less understood. Feminist rights arguments, which materialised in this landmark legislation during the second wave of Feminism, can be retraced in this data. Despite its limitations, midwives still recognise the dangers of unsafe abortion and harrowing recollections of pre-1967 backstreet conditions linger. Hypothesising 'what if?' apocalyptic scenarios, they regularly face dilemmas of achieving coverage for the service-user – if not me, then whom? if not now, then when? because in austere environments, they are left being the last chance.

Against this background, whilst midwives are sympathetic to the standpoints of objectors, they still advocate woman-centredness, without exception. For the large part, this is to the exclusion of other stakeholders, notably the father of the unborn, the unborn, the employer and even the State. Questioning if objectors are in the right job raises questions of orientation to the role. Patient priorities and the needs of the service are prioritised above CO, but that is not to say that CO matters don't matter, nor that rights are not perceived as alright. The nominal number of midwives who have voiced an objection – or even would under certain circumstances – is interesting but this doesn't mean they do not experience dilemmas, challenges to moral integrity or moral distress over doing so. That so few would know how to go about expressing freedom of conscience reflects a lack of policy or a charter committed to the promotion of their rights and vice versa. Guidance from the NMC embodies the premises of section 4 (i) – the conscience clause but that too is far from perfect. Gillian's remarks of this being "the escape clause" implies practitioners sometimes feel trapped or incarcerated by societal assumptions surrounding abortion. The midwives in this study, generally do uphold abortion but decline to participate. How this is operationalised is unclear. The inconsistencies of case-by-case management are equally enigmatic, but lest we not forget that this thesis aims to address the phenomenon that is CO – it is not about the

rights and wrongs of abortion. Marrying up the right midwife to the right care involves wider redress than simple workload allocation. Handover dilemmas do occur, which can be eased by more preparedness, a transparent referral system and open acknowledgement of the legitimacy of CO in when to declare, to whom and how. Generally speaking, the consensus stops short of registration, is deemed inflexible, and the verdict is left unfinished on tribunals for fear they may be punitive rather than supportive in holding practitioners to account.

As heated a debate as that about midwives' right to strike, where do the rights of the public end and consideration of practitioners' welfare begin? - right at the bottom of the heap, suggests Catherine. Ancient philosophical and theological ideas spill into modern day thinking, breaching ever changing boundaries between hospital and the courts, religious places of worship, and parliament. There must be somewhere in the middle for them to meet. Better understanding of the processes of moral reasoning and ethical decision-making will hopefully bridge the impasse caused by entrenched views. Arguably, views are no less moral, legitimate, and valid because freedom of conscience is voiced by a caregiver adopting an ideological position. Inciteful accusations of a lack of Humanitarian concern abound on either side of the increasingly politicised and rights-driven debate. The discernment of the Kantian 'Golden Rule' (do unto others as you would have done to yourself) are just as relevant today as ever. In a liberal democracy where rights are supported, we recall Voltaire's dictate – 'I wholly disapprove of what you say, but I will defend to the death your right to say it'- a sentiment epitomised in this thesis which calls for a new departure in policy: a move from assumption towards tolerance and respect. A system of CO legitimises the facilitation of the premise, recognising that inharmonious imbalances benefit no-one.

The main contribution of the thesis is in a conceptual model which highlights how midwives define conscientious objection and how this can have a bearing on what they judge to be participation in abortion. Clearer understanding of rights and responsibilities will hopefully alleviate the moral distress associated with dilemmas, making theory relevant to practice. The moral reasoning framework will further do this. Relativist and Pragmatist paradigms of ethical decision-making are encouraged which provide practitioners with the tools to tailor the fabric of objection. Rather than a straitjacket recognising one size fits all, when it comes to dealing with the quandaries of freedom of conscience – many midwives wear two hats and a professional uniform but are torn.

---

9. Reflexivity Pit Stop – Post Thesis – What Constitutes Care?

Reflecting back, my ideas on conscientious objection have come full circle. I still remain passionate about women's rights but equally am a fervent defender of my colleagues non-participation, if that what they want. In the jigsaw that is often the 'messy' world of Maternity, the right midwife delivering the right care is imperative and primarily, for me, this is one that respects bodily autonomy, rights to self-determination and healthcare. Not a two-tier service but one that is accessible, equitable, non-judgmental, and appropriate. Abortion is here to stay; no dispute has been that inmost circumstances the current provision of the Abortion Act's four criteria meet the needs of the majority of people. For those with unintended pregnancy, vulnerable and in crisis, to have care that is compassionate and kind, respectful and non-discriminatory is at the heart of care with a heart, to allow people to reconfigure their lives and heal, in their own time, in their own, supported by professionals dedicated to alleviating their suffering.

Admitting its contentious nature, open debate is a pre-requisite to developing appropriately managed CO systems, the recommendations for which will now follow.

Chapter 8 - Conclusion

None of the participants were found to display, as Lord Hale summing up in Doogan versus Woods suggests, a 'repugnance' to participation. Most maintained a moderate position in keeping with Wicclairian accommodation, the 'Spectrum of Views' highlights (see Appendix 10). A conventional compromise is designed to promote the conscience of individual practitioners who combine this with a regard for the greatest happiness of the greatest number. All participants advocated a harmonious working environment in which the workload is shared, safety is maintained, equitable care principles are adhered to, justice is seen to be done, a 'positive' patient experience is achieved, and no harm is inflicted. The priority is woman-centredness. The patients' needs always must come first, they confided, representing as they do, the requirements of the service above and beyond, its practitioners. Part of the way midwives reasoned about conscientious objection was to justify it as a recognised right, so long as its impact is negated. The idea of ignoring patients, inflicting detriment to the needy and turning those in crisis away is what met with disdain, since the implications of inaction are so morally abhorrent.

Rather than revisit origins, focus has been on how practitioners themselves interpret the impact freedom of conscience has on abortion services and how this is morally reasoned. Amongst midwives, avowed to care, how midwives reason the mechanisms with which they decide not is complex. Moral conflict is suppressed, internalised, or compartmentalised as a coping strategy. That's not to say that no distress is experienced in participation, but mostly those who do experience some degree of repugnance, choose career roles other than those abortion related.

Mostly, it appears that conscientious objection is a developmental or transitional concept, metamorphosing over time. Nevertheless, a model of participation has been devised to show how CO definitions (born of background, pre-understandings, and pre-conceptions) are linked to participation, given the Courts calls for closer definition of the term. The language itself is bound with dispute – 'performance' Oderberg (2018) rather would call it.

Whilst a confirmed relationship has been demonstrated between being a practising midwife, practising religion, the rationale for conscience has not been shown to be exclusively theological in origin. Instead, conscientious objection by very definition is much wider: one conscience-based, navigated using a moral compass, a question of spirituality per se.

Universally recognised rights to freedom of conscience are conditional. Attendance at faith services is not a prerequisite to the lived experience of dilemmas, of course, and as a phenomenon objection is highly unique in character, interpretive and individualistic. Regardless of which religious doctrine a midwife may or may not follow. Regardless of whether religious practice is current or retrospective, moral reasoning is ongoing, a tenet of midwifery practice on which contemporary conscience-based decisions rest. Participants with a religious background do show aptitude for the theological conceptualisation of conscientious objection, but equally it has been shown to be motivated by conscience. It is working in sexual and reproductive health which has had most substantial influence on how midwives predominantly feel about objection and indeed abortion rights in general.

Feminist ideology surrounding bodily autonomy, the role of women not only in the home, but in society, is at the impassioned heart of the data. On the topic of rights, data was strong as empowerment, rather than view healthcare as 'a gift'. Another significant determinant of how midwives felt about cases of objection or morally reasoned about involvement was their own personal experience, either of conscience (affecting themselves or their colleagues), abortion, pregnancy, or in fact pregnancy loss. This was in keeping with findings of the literature review but is less well represented in theory. The many true accounts of decision-making scenarios show midwives' humanity. Conscientious objection does affect midwives and midwives think it affects patients. Yet the bigger question of moral reasoning in abortion decision-making show a legally provided service is supported as an essential part of healthcare.

Calling for fairness, accommodation is advocated most by those tasked by society to deal with objection professionally, but it is supported by those wishing to realise reproductive justice. An IPA lens best reflects dilemmas through the eyes of practitioners affected by these challenges. Working within an antiquated system designed to deal with the most vulnerable, unsustainable, or unintended pregnancies, is acknowledged. Participants recognised the need for conscientious objection, even if this is with limits and scope, which the Abortion Act does not necessarily achieve, as these participants perceive it. Growing medicalisation has resurfaced ancient ideologies about what constitutes value and when does life begin? In practical terms, this has redefined the age of biological viability, which medico-legal systems are only just starting to catch up on. Add telemedicine thrown into the covid pandemic mix and the moral dilemmas cascade quickly into something more philosophical which become more concerning for midwives if safety is compromised, for example by non-compliance with administration

protocols. Telemedicine does not eradicate dilemmas, albeit maybe addressing those gestation related ones.

Medical science may have solved old dilemmas, yet created a new language, expressed in the vocabulary of the third theme: 'Fearing – reviving, surviving, thriving'. This encapsulates midwives' Existential dilemmas of being in the room, as the hands-on care provider at the bedside and moral reasoning related to questions like viability and potentiality. Participants drew attention to neonatology in their prediction of ever more likely resuscitation dilemmas – when clinicians feel conflicted by their involvement in abortion given cautious in trepidation around what to do if the baby at birth is shown with signs of life. Participants expressed how tortuous uncertainty and guilt sometimes seeps in, reflecting on sequelae of a life taken. Instantaneous clinical management decisions can inflict on families a lifetime of dependency, and this is another dilemma that leaves participants feeling 'torn between wearing two hats': a professional and personal persona. The lack of time is an influential factor. Determining outcomes with long term implications make the moral decision-making more uncomfortable. This makes Aristotelian understanding of personhood, potentiality, beliefs around the sanctity and value of life just as valid as ever.

My research showed midwives remain predominantly motivated by a humanitarian concern. This concern translates to care when the pregnancy is to be terminated. Putting the patient's safety first, promoting service-user well-being, professionalism and compartmentalising their own feelings are central tenets of midwives' vocational practice. Participants predominantly relied upon virtues-based ethical thinking, acting in accordance with doing no harm, seeing justice and fairness realised before doing good (because remember – what is the beneficent outcome is here being disputed). Consequentialism also comes into play alongside Utilitarianism. Virtues-based ethical reasoning appears to be the model with which practitioners are most familiar and at the heart of how they employ skilful, pragmatic choices to a variety of complex scenarios. The midwives make ethical sense of the dilemmas and CO crises they find themselves faced with by using principles of beneficence, non-maleficence and so on.

Acceptance of abortion per se, however, was conditional - not all participants supported all abortions in all cases – this depended on gestation, parity and justification. Generally, there appeared no sympathy for a 'designer baby culture'. In fact, depending on the congenital condition, and whether it was predicted to be life-limiting, opinions differed. No one participant approved at all of abortion for Trisomy 21, cleft lip and palate. As a

reason to abort some of the justifications were poorly understood including female feticide. Inconsistent application of criteria in making case by case distinctions could "grow horns", as Gillian warned, however. There are implications for antenatal care and education, screening, and diagnostic testing because it is based on a developing science that service-users are being advised. Decisions are being made, based on that advice. The challenges of metering out flexible policy that links the screening and abortion service remain – one size does not fit all.

Extended roles in advanced practice to meet these changing needs make the dynamic ever more fluid, in its CO state of flux. Compared to their historical counterparts, 21st century contemporaries face dilemmas rarely encountered and hardly envisioned in 1967. Such is the murky shadow cast by backstreet abortion, however, that a 'Call the Midwife' component of midwives' moral reasoning drives participants to defend abortion rather than condone it. As pro-feminists, participants accredited the importance of The Abortion Act. On this basis, those participants who partook in procedures did so rather than face an apocalyptic return to pre-1967 conditions.

Participants acknowledged and speculated 'if not me then who? If not now, then when? If not legally, then how?' Many voiced cautions around bucking against trends, fearful of a return to a Victorian age when offences against the person were shockingly commonplace. This was a matter of health as well as civil liberties, they suggested: that realising freedom of conscience was unsatisfactory if it led to infringements on the rights of anyone else.

But 21st Century guidance ought still to alleviate moral distress through accommodation, not side-lining CO. Options explored included a register, Ethical Committees, greater awareness through the pivotal role of Professional Midwifery Advocates, educational curriculums to include sociological and psychological perspectives and values workshops, even involving liaison with service users themselves. Lots of infrastructure already exists which could be adapted – for example, incorporating the functionality of the *hub*, (the intranet online facility with which professionals access local policies and procedures based on NICE guidelines), Healthcare Surveillance Investigation Board-type table-abortion discussions, critical case reviews/investigations and applying the A-EQUIP Model.

Thus, CO is not a stigmatising "taboo" but a legitimate part of employee rights in the workplace. It is formalised, not "an assumption" or "a given". Accommodation of conscientious objection is the way forward in ensuring the right midwife, delivering the

right care. It moves away from the blasé idea that rights can be misappropriated. Abortion care is an automatic part of healthcare. Whilst at the same time turning no one away, accommodation of conscience does not equate to the waving of 'anti-abortion/pro-life' placards in its name. And vice versa, all abortion defenders do not necessarily abhor objection. Accusations of a lack of humanitarianism abound on either side of the debate, but entrenched dictates benefit no-one. Regulation of conscientious objection was as a safety net, not a stick with which to hold objectors to account. Actually, if suitably regulated, measures have the potential to streamline access, reduce delays and reassert partnership in therapeutic relations between service- users and providers, who are 'with woman' without duress and friction is eased in referral systems facilitating delay-free access.

Not for themselves, so much, but for safety, participants display a cautious attitude towards withdrawal of their professional services. They remain mindful of professional guidance, look to regulation for protection, demonstrate an awareness of accusations of misconduct, and are fearful of reprimand in the Courts. Faithful to their oaths taken in Hippocratic tradition, they are proudly defensive of NHS constitutional values, but what they perceive as the greater good remains elusive.

In support of the premise that every human being enjoys an entitlement to expression, conscience and free thought, midwives are largely tolerant and see logic in accommodation. Having lived experience of ethical dilemmas, they fully appreciate the moral reasoning of conscience but fall short of objecting themselves (or undergoing abortion themselves). Whilst most participants maintained a moderate standpoint as abortion-defenders, they recognised the rights of dissenting colleagues with views differing to their own. Like Voltaire remarked "I may not agree with what you are saying, but I will fight to the death your right to say it!"

The current system places the onus on the individual to decide this essentially personal, interpretative, and unique matter, to declare or voice formally, to act out their beliefs, to have those rights respected. In the unpredictable Maternity environment, this has its challenges - all this in the absence of conscience policy. Whilst they may experience disagreement dilemmas around many case-by-case abortion decisions, practitioners endeavour to retract personal personae, in favour of a professional stance. Compartmentalising any sentient reaction, conflict is suppressed in a way that limits moral complicity or culpability for the taking of life because they reassure themselves of the service-users autonomy, 'It is their choice'.

Dealing with different scenarios where midwives may feel 'torn between wearing two hats' have been raised, both in the literature review as professional matters and as a theme in the chapters on findings and the discussion. The largely sophisticated models covered build on seminal work. Thaddeus and Maine's (1987) ideas, albeit superseded, are still valid and relevant since CO delays contribute to maternal mortality. The tragic circumstances of Ana María Acevedo illustrate this in each regard: seeking medical advice, reaching an appropriate level of facility, and receiving adequate care. These models act as a prelude to this thesis' main contribution – a framework on how midwives morally reason and a model of definition and participation to help understand the operationalisation of procedures in terms of what conscientious objection is perceived as comprising. What can be done to ensure safety, and the provision of an Egalitarian, non-discriminatory and non-judgemental service for all? (After all, in the U.K. abortion is a legitimate, universal, and legally endorsed right to an equitable service funded by the taxpayer via an NHS whose constitutional values maintain – from each according to their abilities, to each according to their needs).

Mostly the law is *"good enough" (Catherine 202)* in exacting our current needs, participants told me, though "tweaks" *(Peter 341)* may be needed to answer resurgence of the debate in telemedicine. As pro-feminists, they acknowledged the importance of The Abortion Act and partook in procedures apocalyptically hypothesising that if not me then who? If not now, then when? If not legally, then how? Fearful of a return to a Victorian age when offences against the person were commonplace.

8.1 Implications of the Research

Based on these findings, closer re-definition of the age of viability around the cusp of life is seemingly integral to interpretations of what comprises legal abortion. Not for whom, but when. The fearing reviving, surviving, and thriving theme highlights lived experience of dilemmas that practising midwives incur which may not be unique to the midwifery profession. The lines are so blurred between neonatology and midwifery/medicine that there are implications for other specialities.

Much moral reasoning is undertaken in this hybrid way and ethical decision-making is applied with responsiveness to the circumstantial evidence. As an ethical theory or theories, this is a hybrid approach applied in a pragmatic way. This is precisely the kind of flexible qualities desirable in a moderate conscience policy. Participants adhered to moderation largely because they recognised the potential for harm to be done in unsafe

abortion, bucking trends of the last fifty years which have witnessed dramatic declines in maternal mortality and morbidity and improving neonatal outcomes.

Overwhelming support for legal rights to a universal service recognises the inherent assumption that this is about equitable access and care. Enshrined in the NHS constitution, these values apply for us as much as anyone else, as members of the community we serve. This has been the benefit of using IPA as a research methodology: a sense of shared ownership. The expanding horizons of understanding facilitated by the sense and meaning making have fostered a dual co-production of knowledge, but one that is still idiographic, and participant led. Using IPA has provided bottom-up solutions to a contentious philosophical subject. This is relevant to maternity practically as it provides the evidence-base to make them workable. Any recommendation will build on their lived experience of ethical decision-making.

The significance of understanding the midwife's role and the quandaries they experience in participating in abortion procedures has, in this IPA study, been shown to be underestimated with a potential to snowball. Reconfiguration of services changing the dynamics of the midwifes' role calls for review of what comprises participatory aspects. It impresses the importance of a greater awareness of rights to accept those who reject societal assumptions. The contradiction between people's motivation for joining a profession and what actually midwives are tasked to do is emphasised in the study. Orientation of the job description related to sexual and reproductive health is imperative, as is CO policy. Just how diverse the needs of the pregnant service-user are is reiterated in the study – and how expansive the midwife needs to be in meeting those needs, including when the pregnancy is unintended, unwanted, or unsustainable. What is clear is how few participants anticipate these dilemmas. Learning about ethical questions and reflecting on decision-making is to arm professionals with resilience tools. The tenets of CO decision-making may be foundational long before career choices are made, but the opportunity for reflection in a safe space is the first of many building blocks. Even as qualified practitioners, these dilemmas are still faced because CO is so contextualised. The concept of CO crisis is very much a lived experience, therefore, so there are implications for preceptorship, and using existing infrastructures to better support objecting midwives at organisational level.

8.2 Limitations of the Study

Whilst purposively selected for their expertise, only a handful of the study participants had taken part in abortion and/or were in abortion-providing settings but regardless of

this, the insight into decision-making around CO was invaluable, the result of formidable moral reasoning undertaken at large in midwifery practice in general. Participants exercised choice too, they told me. Most speculated about scenarios when they would conscientiously object. However, some of the midwives could only project ideas for a course of action if they did wish to exercise freedom of conscience. On this basis, training focused on rights awareness – what to do if you morally reason and decide ethically that abortion is objectionable - may be beneficial. How best to facilitate safety for the proportion of women for whom pregnancy and childbirth are not wholly positive is an integral part of that, such as the duty to refer and the duty of care in emergencies.

Just as every life matters, every voice counts, but there exists no forum for debating the transparency of moral reasoning, no ethical committees nor policy or objectors' charter in any of the institutions studied. Although codes of conduct and position statements do exist from professional bodies, support is described as very unsubstantial at organisational level. Regulation, whose role is so pivotal in the A-EQUIP model (NHS England 2017), does feature in the data but that participants did not mention revalidation, for example, is a limitation of the study. This is the professional requirement to renew registration as a nurse, midwife, or nursing associate. Midwives need to demonstrate fitness to practice, to the Nursing and Midwifery Council based on a local evaluation of practice through appraisal of practice hours, continuing professional development, feedback, reflection and confirmation.

The taboos associated with objection seen as a kind of dissent or non-compliance (in 'dishonourable disobedience' (Fiala and Arthur 2014) have been one of the challenges of the study. This may also prove to be a limitation: that participants were mindful of repercussions.

8.3 Recommendations for Further Research

Further research into the practical application of the framework and model may be necessary. If used in a prescriptive manner, participants may find its novelty of limited real help because of the iterative nature of moral reasoning. Rather, the aim is to support consistency in ethical decision-making to move away from case-by-case distinctions, with its connotations of judgmental and discriminatory abortion care. Where blanket policy fails, the framework aims to assist midwives in their reflective practice. The framework encourages a more comprehensive way of rationalising decisions, not to be pressured or told that decision is wrong. It will hopefully be an enabler to alleviate the moral distress shown to be associated with CO and prevent the sequelae that midwives

need to go to the Courts in order to practice as they see fit. Equipping practitioners with the moral tools, to defend their practice best on the most ethical decision-making will benefit all parties and stakeholders. It reinforces accountability yet punishes no-one for their CO beliefs. Suitably regulated accommodation of CO serves to structure participation in a more openly transparent context that is responsive and collaborative, without detriment to the service-user or negating care. Better ethical reasoning thus is a win: win, envisioned to be achieved in the following policy recommendations:

8.4 Policy Recommendations

- Establishment of policy guidance within institutions available to all staff and employers at Trust level available through 'The Hub'
- Commissioning of a CO Charter available through professional bodies, the RCM and NMC as part of an i-learn package.
- For further evaluation into Ethical Committees at organisational level
- Recognition of the pivotal role of Professional Midwifery Advocates in support of CO rights within the A-EQUIP Model
- Setting up Values Clarification workshops, raising awareness of CO in the workplace for Maternity Co-ordinators to determine how moderate compromise solutions could be locally metred with openness and transparency.
- Educational curriculums to include sociological/psychological perspectives on CO using practical scenarios and reflections Involving a partnership with service users (such as Maternity Voices) may make some headway towards harmonising this with the patient experience Local solutions examining how best to ensure coverage, availability and accessibility should not be stigmatising and show due regard for objector confidentiality.

The opportunities in the current climate are well recognised by participants. The time is ripe for a judicial review to examine, for example, the pros/cons of reducing the legal age of viability and better neonatology guidance on potentiality. Since UK government reports have demonstrated its main messages, that safety and women's choice are paramount, the way is paved for progress which ensures the kind of service that people want which is responsive, respectful, and researched. It also is a sexual and reproductive health service in which midwives' feel valued for their views.

10. Reflexivity Pit Stop - Post-thesis – What Do I Think Constitutes The Gold Standard?

My research decisions reflected this wariness of recommendations which could potentially give professionals carte blanche. At data collection, for example, I probed on registers of objectors' and tribunals – ethical committees were a compromise solution reflecting how steadfast I remain. Analysis of the data reflected most keenly what I had read on non-punitive, fair treatment at tribunals – a touch light when they appeared at interview. Like most commentary seems to intimate, I interpreted participants veered against registration, rebutted hard or fast rules and preferred instead being held to account in alternative ways to tribunals. The gold standard of care is consent and respect for patient autonomy is pivotal in that. I am a strong believer in more specific policy – there currently is none at organisational level. The inconsistencies brought about by its absence require managers to make it up as they go along - leaps of faith which are fair neither on the objectors or her employer, but especially not on the patient.

8.5 Summary of Findings/Key Points

- Accommodation of CO is worthwhile, but with limitations. Alternative schools of thought (ranging from absolutism to incompatibility) are available, but extremist viewpoints are controversial and not well evaluated by those participants in this study.
- To maintain safety, support a legitimately provided, legally endorsed, accessible abortion service, more open and transparent CO debate remains a pre-requisite.
- The commitment to see no harm done remains a foundation of the midwifery ethos but the transparency of how midwives morally reason to achieve this remains unclear and ethical decision-making complexities are as strongly as ever.
- The origins of CO are more multi-factorial than commonly assumed. They are in fact, widely conscience-based and motivation for CO can depend on personal experience and idiographic interpretation.
- Midwives' lived experience of the phenomenon is riddled with assumptions and taboos. The resistance to publicly endorse contemporary CO (in the failure of the CO (Medical Activities) Bill) shows how strong the culture of silence can be.

- Greater awareness of rights, responsibilities and obligations could clarify the scope and limitations of midwives' CO.
- Ethical Review Committees or perhaps a charter would affirm the political commitment.
- Practical ways of achieving a harmonious balance of rights are needed, especially in referrals, emergencies, and participatory acts of fetal demise.
- The lack of policy deters progress, but options such as registration of objectors are unsupported.
- Worldwide patchy coverage of abortion services is mirrored by UK-based inconsistencies and legal loopholes which mean review is necessary largely because of a change in the Maternity environment. In doing so, there is potential to impact on the lives of millions who still are estimated to be hospitalised annually as a result of the complications of unsafe abortion.
- Participants praised the Abortion Act's feminist trailblazing. Rather than face a return to a "Call the Midwife" apocalypse, midwives in this study supported legal abortion speculated 'If not me then who? If not now, then when? If not legally, then how? but still underwent many ethical dilemmas.
- Using IPA as a research methodology helped identify these, providing insight into the angst moral reasoning that accompanies decision-making.
- A pragmatic approach to ethical theory is favoured in practice which balances the rights of the individual with the needs of the majority.
- 21st Century accommodation, neither side-lines objectors nor prejudices service-users. Not an assumption or a given. Suitably regulated measures have the potential to reaffirm human rights for all and actually may streamline access ensuring the right midwife delivering the right care.

References

Adenitire, J. O. (2016) The BMA's Guidance on Conscientious Objection May Be Contrary to Human Rights Law *Journal of Medical Ethics* [online] 43 (4) 260–263 Available from https://doi.org/10.1136/MEDETHICS-2015-103222 [Accessed 05/01/2023]

Ahern, K.J. (1999) Ten Tips for Reflexive Bracketing *Qualitative Health Research* [online] 9 (3) 407-411 Available from https://doi.org/10.1177/104973239900900309 [Accessed 05/01/2023]

Aisbett, D. (2006) Interpretative Phenomenological Approaches to Rural Mental Health Research *Rural Social Work and Community Practice* [online] 11 (2006) 52-58 Available from https://api.semanticscholar.org/CorpusID:157834690 or http://researchonline.federation.edu.au/vital/access/HandleResolver/1959.17/64547 [Accessed 12/02/2023]

Alase, A. (2017) The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach *International Journal of Education and Literacy Studies* [online] 5 (2) 9-19 Available from https://doi.org/10.7575/aiac.ijels.v.5n.2p.9 [Accessed 05/05/2023]

Al-bar, M. and Chasmi-Pasha, H. (2015) Virtue Ethics and Moral Character Related to Medical Profession. In: Al-Bar, M. and Chasmi-Pasha, H. (Eds.) *Contemporary Bioethics: Islamic Perspective* [online] Pp.75-84, USA: Springer Available from https://www.ncbi.nlm.nih.gov/books/NBK500189/ or https://doi.org/10.1007/978-3-319-18428-9_4 [Accessed 16/08/20222]

Almutairi, M. (2007) *The Relationship Between Religion and Law in The Sphere of Abortion Regulation: A Case Study of Saudi Arabia and Ireland* [online] Available from https://www.academia.edu/35519610 Master's thesis, University of Maynooth, Ireland [Accessed 16/06/2022]

Ambast, S., Atay, H. and Lavelanet A. (2023) A Global Review of Penalties for Abortion-related Offences in 182 Countries *British Medical Journal Global Health* [online] 8 (3) e010405
Available from https://doi.org/10.1136/bmjgh-2022-010405
[Accessed 02/08/2022]

Amery, F. (2014) *Abortion, Politics in the UK: Feminism, Medicine, and the State* [online] PhD thesis, University of Birmingham, UK
Available from www.etheses.bham.ac.uk/id/eprint/4950/
[Accessed 01/11/2021]

Anderson, E. (2019) Dewey's Moral Philosophy In: Zalta, E.N. and Nodelman, U. (eds.) *The Stanford Encyclopaedia of Philosophy* [online] Winter 2019 Edition
Available from https://plato.stanford.edu/archives/win2019/entries/dewey-moral
[Accessed 13/02/2022]

Andre, C. And Velasquez, M. (1991) For Your Own Good *Issues in Ethics* [online] 5 (2) Epub. 13/112015
Available from www.scu.edu/ethics
[Accessed 26/04/2022]

Appendix 7:
Critical Appraisal Skills Programme (2022) Systematic Review Checklist [online]
Available from https://www.casp-uk.net/casp-tools-checklists/
[Accessed 30/10/2023]

Appendix 8:
Reasons Why Women Have Abortions [online]
Chae, S., Desai, S., Crowell, M. and Sedgh G. (2017) Reasons why women have induced abortions: a synthesis of findings from 14 countries. *Contraception* 96(4):233-241. doi: 10.1016/j.contraception.2017.06.014. Epub 2017 Jul 8
Available from https://www.contraceptionjournal.org/article/S0010-7824(17)30188-9/fulltext
[Accessed 28/10/2023]

Appendix 9:
Broad Reasons Used to Argue For/Against CO [online image]

Fleming, V., Frith, L., Luyben, A. and Ramsayer, B. (2018) Conscientious Objection to Participation in Abortion by Midwives and Nurses: A Systematic Review of Reasons *BMC Medical Ethics* [online] Epub. 27/04/2018; 19 (1) 31
Available (online) from https://doi.org/10.1186/s12910-018-0268-3
[Accessed 20/10/2023]

Appendix 11:
A Case Study: Ana Maria Acevado [online]
Association of Women's Rights in Development (2007) The Death of Ana Maria Acevado: Rallying Cry for the Women's Movement. Multisectorial de Mujeres de Santa Fe, Argentina.
Available from https://womenslinkworldwide.org
[Accessed 29/10/2023]

Arendt, H. (1929) Der Liebesbegriff bei Augustin: Versuch einer philosophischen Interpretation *[On the Concept of Love in the Thought of Saint Augustine: Attempt at a Philosophical Interpretation]* [online] PhD thesis, Department of Philosophy, University of Heidelberg (in German) Trans. Jasper, K. (2006) Der Liebesbegriff bei Augustin: Versuch einer philosophischen
Available from https://www.researchgate.net/publication/34993287
[Accessed 25/10/2023]

Arendt, H. (1978) Thinking pp. 50-53. In. Arendt, *The Life of the Mind* UK: Harcourt [online]
Available from https://www.academia.edu/33478253/
[Accessed 26/10/2023]

Arendt, H. (2009) *Responsibility and Judgment* p.36, USA: Schocken Books cited in: Vetlesen, A. J. (2001) Hannah Arendt on Conscience and Evil *Philosophy & Social Criticism* [online] 27 (5) 1–33
Available from https://doi.org/10.1177/019145370102700501
[Accessed 21/10/2023]

Armstrong, E. (2020) Marxist and Socialist Feminism *Study of Women and Gender* Faculty Publications, Smith College, Northampton, MA. [online]
Available from https://scholarworks.smith.edu/swg_facpubs/15

Accessed 23/05/2024

Aromataris, E., Fernandez, R., Godfrey, C., Holly, C., Kahlil, H. and Tungpunkom P. (2015) Summarizing Systematic Reviews: Methodological Development, Conduct and Reporting of an Umbrella Review Approach *International Journal of Evidence Based Healthcare* [online] 13 (3) 132-40
Available from https://doi.org/10.1097/XEB.0000000000000055 or https://journals.lww.com/ijebh/fulltext/2015/09000
[Accessed 15/02/2023]

Aurthur, J.A. Gemzel, K.D., Germundsson, J.A. and Fiala, C. (2016) Yes! We Can! Successful Examples of Disallowing Conscientious Objection in Reproductive Health Care *European Journal of Contraception and Reproductive Health Care* [online] 21 (3) 201-206
Available from https://doi.org/10.3109/13625187.2016.1138458
[Accessed 17/11/2022]

Avasthi, A., Ghosh, A., Sarkar, S. and Grover, S. (2013) Ethics in Medical Research: General Principles with Special Reference to Psychiatry Research *Indian Journal Psychiatry* [online] 55 (1) 86–91
Available from https://doi.org/10.4103/0019-5545.105525
[Accessed 30/03/2022]

Bacon, I., McKay, E., Reynolds, F. and McIntyre, A. (2020) The Lived Experience of Co-dependency: an Interpretative Phenomenological Analysis *International Journal Mental Health Addiction* [online] 18: 754–771
Available from https://doi.org/10.1007/s11469-018-9983-8
[Accessed 15/11/2022]

Baghini, F. K., Iranifard, E., Latifnejad Roudsari, R., Mirzaii Najmabadi Kh. T. (2023) The Role of Midwives in Women's Empowerment: A Narrative Review. *Journal of Midwifery and Reproductive Health* 11(3):pgs. 3767-3781 [online]
Available from http://doi:10.22038/JMRH.2022.68761.2016
Accessed 20/05/2024

Bailey, J. (2008) First Steps in Qualitative Data Analysis: Transcribing. *Family Practice* [online] 25 (2) 127-31

Available from https://doi.org/10.1093/fampra/cmn003 Epub 27/02/2008
[Accessed 04/10/2021]

Bailey, J. (2012) *Abortion.* Rosen Publishing Group, USA: New York

Beauchamp, T. And Childress J. (2013) *Principles of Bioethics.* 7th ed. USA: Oxford University Press

Beckwith, F. (2010) Michael Tooley, Abortion: Three Perspectives Faith and Philosophy: *Journal of the Society of Christian Philosophers* [online] 27 (4) Article 11
Available from https://doi.org/10.5840/faithphil201027450 or
https://place.asburyseminary.edu/faithandphilosophy/vol27/iss4/11
[Accessed 11/08/2022]

Beckwith, F. (2007) *Defending Life: A Moral and Legal Case Against Abortion* Cambridge University Press, USA

Bedwell, C. (2012) An Analysis of the Meaning of Confidence in Midwives Undertaking Intrapartum Care. PhD thesis. (Manchester eScholar - The University of Manchester) [online]
Available from https://www.escholar.manchester.ac.uk/jrul/item/?pid=uk-ac-man-scw:162969
Accessed 15/05/2024

Ben-Moshe, N. (2019) The Truth Behind Conscientious Objection in Medicine *Journal of Medical Ethics* [online] 45 (6) 404-410
Available from https://doi.org/10.11336/medethics2018-1105332
[Accessed 19/12/2021]

Berlinger, N. (2008) Conscience Clauses, Healthcare Providers and Parents In: From Birth to death, Bench to Clinic – *The Hastings Center Briefing Book for Journalists,* Policymakers and Campaigners, Crowley, M. (ed.) pp. 35-40, NY: Garrison
Available from https://www.hastingscenter.org/wp-content/uploads/Conscience-Clauses-BB8.pdf
[Accessed 15/12/2022]

Bernstein, R.J. (1982) From Hermeneutics to Praxis *Review of Metaphysics* [online] 35 (1982) 823-845

Available from https://www.jstor.org/stable/20127742
[Accessed 23/10/2023]
Bhaskar, R. (2008) *A Realist Theory of Science*. New York: Routledge

Biggerstaff, D. and Thompson, A. (2008) Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research *Qualitative Research Psychology* [online] 5 (3) 214-224
Available from https://doi.org/10.1080/14780880802314304
[Accessed 20/10/2023]

Birchley, G. (2012) A Clear Case for Conscience in Healthcare Practice *Journal of Medical Ethics* [online] 2012 (38) 13-17
Available from https://doi.org/10.1136/jme.2011.043653 Epub 27/06/2011
[Accessed 20/10/2023]

Birt, L, Scott S, Cavers D, Campbell C, Walter F. (2016) Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*. [online] 26 (13) 1802-1811
Available from https://doi.org/10.1177/1049732316654870 Epub 10/07/2016
[Accessed 20/10/2021]

Black, K. (2010) *Business Statistics: Contemporary Decision-Making* 6th edition, USA: John Wiley & Sons

Blumer, H (1969) *Symbolic Interactionism: Perspective and Method*. USA: Berkeley: University of California Press.

Blundell, P., Burke, B., Wilson, AM.. and Jones, B. (2022) Self as a Teaching Tool: Exploring Power and Anti-oppressive Practice with Counselling/Psychotherapy Students. Psychotherapy and Politics International, 20 (3) Pgs. [online]
Available from: https://researchonline.ljmu.ac.uk/id/eprint/17278
Accessed 17/05/2024

Blundell, P. and Oakley, L. (2024) Missing People and Fragmented Stories: Painting Holistic Pictures Through Single Pen Portrait Analysis (SPPA), *Qualitative Research in Psychology* [online] 21 (1) 44-70
Available from https://doi.org/10.1080/14780887.2023.2285066
Accessed 29/04/2024

Boama, V. (2018) Conscientious Objection and the Abortion Doctor *International Journal Obstetrics and Gynaecology* [online] 143 (4) 263
Available from https://doi.org/10.1002/ijgo.12662
[Accessed 01/10/2019]

Boell, S. K. and Cecez-Kecmanovic, D. (2014) A Hermeneutic Approach for Conducting Literature Reviews and Literature Searches *Communications of the Association for Information Systems* [online] 32 (2014) 257-286
Available from https://doi.org/10.17705/1CAIS.03412
or https://www.researchgate.net/publication/263580752
[Accessed 20/10/2023]

Bonache, J. and Festing, M. (2020) Research Paradigms in International Human Resource Management: An Epistemological Systematisation of the Field *German Journal of Human Resource Management* [online] 34 (2) 99-123
Available from https://doi.org/10.1177/2397002220909780
[Accessed 20/10/2023]

Boyle, M. and Armstrong, C. (2009). Measuring Level of Deviance: Considering the Distinct Influence of Goals and Tactics on News Treatment of Abortion Protests. *Atlantic Journal of Communication* [online] 17 (4) 166-183
Available from https://doi.org/10.1080/15456870903156134
[Accessed 20/10/2023]

Braun, V. and Clarke, V. (2013) *Qualitative Research Methods* Sage Publications, London, UK

British Broadcasting Corporation (2019) *Abortion – Religious section* [online]
Available from https://www.bbc.co.uk/ethics/abortion/religion/religion.shtml
[Accessed 22/09/2019]

British Medical Association (2018a) *Expression of Doctors' Beliefs* [online]
Available from www.bma.org.uk/advice/employment/ethics/expressions-of-doctors-beliefs
[Accessed 14/09/2019]

British Medical Association (2018b) *The Law and Ethics of Abortion - BMA Views* [online]
Available from https://www.bma.org.uk/advice-and-support/ethics/abortion/the-law-and-ethics-of-abortion
[Accessed 14/09/2019]

British Medical Association (2019a) *Expressing Your Personal Beliefs as a Doctor* [online]
Available from https://www.bma.org.uk/advice-and-support/ethics/abortion
[Accessed 23/04/2020]

British Medical Association (2019b) *The Removal of Criminal Sanctions for Abortion: BMA Position Paper*
Available from www.bma.org.uk/media/1142
[Accessed 23/04/2020]

Brock, D.W. (2008) Conscientious Refusal by Physicians and Pharmacists: Who is Obligated to Do What, and Why? *Theoretical Medical Bioethics* [online] 29 (3) 187-200
Available from https://doi.org/10.1007/s11017-008-9076-y
[Accessed 20/10/2023]

Brown, W. (2000) Suffering Rights as Paradoxes *Constellations* [online] 7 (2) 208-229
Available from https://doi.org/10.1111/1467-8675.00183
[Accessed 20/10/2023]

Bruce, F. (2018) Why Conscientious Objection in the Medical Profession Must Be Protected *House Magazine* [online]
Available from https://www.politicshome.com
[Accessed 19/03/2019]

Buchbinder, M. (2016) *Reframing Conscientious Care: QA with Mara Buchbinder Hastings Center for Ethics* [online] 46 (2016) 22-30
Available from https://www.thehastingscenter.org/reframing-conscientious-care-qa-with-mara-buchbinder or https://onlinelibrary.wiley.com/doi/10.1002/hast.545
[Accessed 20/10/2023]

Byrnes, J. (2021) The Problem of “Core Moral Beliefs” as the Ground of Conscientious Objection *HEC Forum* [online] 33 (3) 291–305
Available from https://doi.org/10.1007/s10730-020-09425-5
[Accessed 20/10/2023]

Cantens, B. (2019) *A Critical Introduction to The Ethics of Abortion – Understanding the Moral Arguments* UK: Bloomsbury Academic

Carlson, J. (2010) Avoiding Traps in Member Checking *The Qualitative Report* [online] 15 (5), 1102-1113
Available from http://www.nova.edu/ssss/QR/QR15-5/carlson.pdf
Accessed 07/05/2024

Caro, D. (2009) Integrating Integrating Gender in Reproductive Health and HIV Programs: From Commitment to Action. 2nd ed.
Available from https://www.igwg.org/wp-content/uploads/2017/04/manualintegrgendr09_eng.pdf
Accessed 23/05/2024

Carter, M. J. and Fuller, C. (2015) Symbolic Interactionism *Sociopedia.isa* [online] 1 (1) 1-17
Available from https://doi.org/10.1177/205684601561
[Accessed 20/10/2023]

Celık, M., Tabak, A., Uysal, M.P., Sıgrı, U. and Turunc, O. (2010) The Relationship between Burnout and Emotional Labour of the Employees in the Hospital Sector *International Journal of Business and Management Studies*. June 2010; 2 (1) pgs. 47-54 [online]
Available from https://dergipark.org.tr/en/pub/ijbms/issue/26070/274756
Accessed 21/05/2024

Chae, S., Desai, S. and Sedgh, G. (2017) Reasons Why Women Have Induced Abortions: A Synthesis of Findings from 14 Countries *Contraception* [online] Epub. 08/10/2017; 96 (4) 233–241
Available from https://doi.org/10.1016/j.contraception.2017.06.014
[Accessed 20/10/2023]

Charalambous, A. Papadopoulos, I.R. and Beadsmoore, A. (2008) Ricoeur's Hermeneutic Phenomenology: An Implication for Nursing Research *Scandinavian Journal of Caring Science* [online] 22 (4) 637-42
Available from http://doi.org/10.1111/j.1471-6712.2007.00566.x Epub 16/10/2008 [Accessed 20/10/2023]

Charlick, S., Pincombe, J., McKellar, L. and Fielder, A. (2016). Making Sense of Participant Experiences: Interpretative Phenomenological Analysis in Midwifery Research *International Journal of Doctoral Studies* [online] 11 (2016) 205-216
Available from https://doi.org/10.28945/3486
or https://www.researchgate.net/publication/320655539
[Accessed 20/10/2023]

Chavkin, W., Swerdlow, L. and Fifield, J. (2017) Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study *Health Human Rights* [online] 19 (1) 55-68
Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5473038/
[Accessed 20/10/2023]

Chervenak, F.A. McCullough, L. and Brent RL. (2011) The Professional Responsibility Model of Obstetrical Ethics: Avoiding the Perils of Clashing Rights *American Journal of Obstetrics and Gynaecology* [online] 205 (4) 315 - e1-5
Available from https://doi.org/10.1016/j.ajog.2011.06.006 Epub 12/06/2011
[Accessed 20/10/2023]

Chervenak, F. and McCullogh, L. (2003) The Fetus as a Patient: An Essential Concept for the Ethics of Perinatal Medicine *American Journal of Perinatology* [online] 20 (8) 399-404
Available from https://doi.org/10.1055/s-2003-45383
[Accessed 20/10/2023]

Childress, J. (1979) Appeals to Conscience *Ethics* [online] 89 (4) 315-35
Available from https://www.jstor.org/stable/2379822
[Accessed 26/10/2023]

Chmielewska B, Barratt I, Townsend R, Kalafat E, van der Meulen J, Gurol-Urganci I, O'Brien P, Morris E, Draycott T, Thangaratinam S, Le Doare K, Ladhani S, von Dadelszen P, Magee L, Khalil A. (2021) Effects of the COVID-19 Pandemic on Maternal and Perinatal Outcomes: A Systematic Review and Meta-Analysis *Lancet Global Health* 9 (6) e759-e772.
Available from https://doi.org/10.1016/S2214-109X(21)00079-6 Epub 31/03/2021
[Accessed 20/10/2023]

Cholbi, M. (2018) Public Cartels, Private Conscience *Politics, Philosophy and Economics* [online] 1 (22) 3801 – 3822
Available from https://doi.org/10.1177/1470594X18779146
[Accessed 14/11/2019]

Clarke, H. (2022) *Woman with Down's Syndrome Loses Abortion Law Appeal* [online]
Available from www.bbc.co.uk/news-disability/63744073
[Accessed 20/10/2023]

Clarke, S. (2016) Conscientious Objection in Healthcare, Referral and the Military Analogy *Journal of Medical Ethics* [online] 43 (4) 218 - 221
Available from https://doi.org/10.1136/medethics-2016-103777
[Accessed 20/10/2023]

Clarke, S. (2017) Two Concepts of Conscience and their Implications for Conscience-Based Refusal in Healthcare *Cambridge Qualitative Healthcare Ethics* [online] 26 (1) 97-108
Available from https://doi.org/10.1017/S0963180116000670
[Accessed 20/10/2023]

Clarke, S. (2019) Some Difficulties Involved in Locating the Truth Behind Conscientious Objection in Medicine *Journal Medical Ethics* [online] 45 (10) 679 - 680
Available from http://doi.org/10.1136/medethics-2019-105748
[Accessed 02/09/2019]

Clarke, V. (2010) Review of the book “Interpretative Phenomenological Analysis: Theory, Method and Research”. *Psychology Learning & Teaching*, 9, 57-56. (cited in Noon, E. (2018)

Clement, G. (2019) Feminist Ethics. In International Encyclopedia of Ethics [online]

Available from https://doi.org/10.1002/9781444367072.wbiee108.pub2
Accessed 23/05/2024

Cline, A. (2021) *3 Types of Ethical Systems - What You Should Do Versus What Type of Person You Should Be* [online]
Available from https://www.learnreligions.com/atheism-types-of-ethical-systems-4058406
[Accessed 03/09/2021]

Cohen, M., Kahn, D. and Steeves, R. (2000) *Hermeneutic Phenomenological Research: A Practical Guide for Nurse Researchers (Methods in Nursing Research)* 1st ed. USA: SAGE Publications

Collins, J.A. and Fauser, B.C.J.M. (2005) Balancing the Strengths of Systematic and Narrative Reviews *Human Reproduction Update* 11 (2) pgs.103-4 cited in Bedwell (2012)

Collins, R. (1994) *The Micro-Interactionist Tradition. Four Sociological Traditions* USA: OU Press

Conrad, P. (1987) The Experience of Illness: Recent and New Directions *Research in the Sociology of Health Care* [online] 6 (1987) 1-31
Available from https://www.science.open.com/document?vid=f6801e70-7523-4d5e-8452-28a4960794e3
[Accessed 21/10/2023]

Cowley, C. (2016) Conscientious Objection in Healthcare in the UK – Why Tribunals Are Not the Answer *Journal of Medical Ethics* [online] 42 (206) 69-72
Available from https://doi.org/10.1136/medethics-2015-102692 Epub 17/04/2015
[Accessed 20/10/2023]

Coyle, D. (2014) Phenomenology. In A. McIntosh-Scott, T. Mason, E. Mason-Whitehead, & D. Coyle (Ed.), *Key Concepts in Nursing and Healthcare Research* (pp. 116-124). London: Sage (cited in Noon, E. (2018)

Creswell, J.W. and Creswell, J.D. (2013) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* 4th ed. USA: Sage Publications

Critical Appraisal Skills Programme (2022a) CASP Critical Appraisal Tool for Systematic Review [online]
Available from https://casp-uk.net/glossary/systematic-review/
Accessed 16/05/2024

Critical Appraisal Skills Programme (2022b) CASP Checklist for Qualitative Research [online]
Available from https://casp-uk.net/checklists/casp-qualitative-studies-checklist-fillable.pdf
Accessed 16/05/2024

Crotty, M. (2003) *The Foundations of Social Research - Meaning and Perspective in the Research Process*, 1st ed. USA: Sage Publications

Cudjoe, E. (2022) Using Diaries with Interpretative Phenomenological Analysis: Guidelines from a Study of Children Whose Parents Have Mental Illness *International Journal of Qualitative Methods* [online] 21 (2022) 1-9
Available from https://doi.org/10.1177/16094069221084435
[Accessed 20/10/2023]

Czarnecki, D. Anspach RR., De Vries, RG., Dunn, MD, Hauschildt, K. and Harris LH. (2019) Conscience Reconsidered: The Moral Work of Navigating Participation in Abortion Care on Labor and Delivery. *Social Sciences Medicine* [online] 232 (2019) 181-189
Available from https://doi.org/10.1016/j.socscimed.2019.03.034 Epub 23/03/2019
[Accessed 20/10/2023]

Daly, K., and Chesney-Lind, M. (1988). Feminism and Criminology. *Justice Quarterly 5* (4) pgs. 497–538 [online]
Available from https://doi.org/10.1080/07418828800089871
Accessed 23/05/2024

De Loyola González-Salgado, I., Rivera-Navarro, J., Gutiérrez-Sastre, M., Conde, P. and Franco, M. (2022) Conducting Member Checking within a Qualitative Case Study on Health-related Behaviours in a Large European city: Appraising Interpretations and Co-Constructing Findings *Health* [online] Epub. 13/07/2022; 13:13634593221109682
Available from https://doi.org/10.1177/13634593221109682
[Accessed 23/10/2023]

De Londras, F. (2018) The Eighth Amendment and Right to Conscientious Objection *The Irish Times* [online] 06/04/2018 on 00.07
Available from https://www.irishtimes.com/opinion/letters/the-eighth-amendment-and-right-to-conscientious-objection-1.3451858
[Accessed 05/06/2023]

Dennison, M. (2019) IPA: The Black Swan of Qualitative Research *Item Qualitative Methods in Psychology Bulletin*. 27: Spring 2019 [online]
Available from http://hdl.handle.net/10454/16955
[Accessed 23/05/24]

Dhollande, S., Taylor, A., Meyer, S., and Scott, M. (2021) Conducting Integrative Reviews: A Guide for Novice Nursing Researchers. *Journal of Research in Nursing*, 26 (5) pgs. 427–438 [online]
Available from https://doi.org/10.1177/1744987121997907
[Accessed 15/05/2024]

de Visser, R.O., Nwamba, C., Brearley, E., Shafiei, V. and Hart, L. (2024) Remote consultations in primary care: Patient experiences and suggestions for improvement. *Journal of Health Psychology* [online]
Available from https://journals.sagepub.com/doi/full/10.1177/13591053241240383
[Accessed 06/05/2024]

Demuth, C. and Mey, G. (2015) Qualitative Methodology in Developmental Psychology, In: Wright, J. (ed.) *International Encyclopaedia of the Social & Behavioural Sciences* [online] (2nd Edition), UK: Elsevier p. 668-675
Available from https://doi.org/10.1016/B978-0-08-097086-8.23156-5
(https://www.sciencedirect.com/science/article/pii/B9780080970868231565)
[Accessed 21/10/2023]

Denzin, N.K. and Lincoln, Y.S. (2018) The Discipline and Practice of Qualitative Research p.1-19 In: Willig, C. and Stainton-Rogers, W. *The SAGE Handbook of Qualitative Research* 5th ed. USA: Sage Publications

DeJonckheere, M. and Vaughn, LM. (2019) Semi-Structured Interviewing in Primary Care Research: A Balance of Relationship and Rigour *Family Medical Community Health* [online] 08/03/2019; 7 (2) e000057

Available from https://doi.org/10.1136/fmch-2018-000057
[Accessed 20/10/2023]

Deterding, N. M. and Waters, M. C. (2018) Flexible Coding of In-depth Interviews: A Twenty-first Century Approach *Sociological Methods and Research* [online] 50 (2) 708 - 739
Available from https://doi.org/10.1177/0049124118799377
[Accessed 20/10/2023]

Dickens, B.M. and Cook, R.J. (2000) The Scope and Limits of Conscientious Objection. *International Journal of Gynaecology and Obstetrics* [online] 71 (1) 71-7
Available from https://doi.org/10.1016/s0020-7292(00)00330-1
[Accessed 20/10/2023]

Dickens, B.M. and Cook, R.J. (2011) Conscientious Commitment to Women's Health *International Journal of Gynaecology and Obstetrics* [online] 113 (2) 163–166
Available from https://doi.org/10.1016/j.ijgo.2011.02.002 Epub 21/03/2011
[Accessed 20/10/2023]

Dickens, B.M. (2021) Conscientious Objection and the Duty to Refer *International Journal of Gynaecology and Obstetrics* [online] 155 (3) 556–560
Available from https://papers/ssrn.com/sol3/papers.cfm?abstract_id=3934046
[Accessed 24/10/2023]

Dobrowolska, B, McGonagle I, Pilewska-Kozak A, Kane R. (2020) Conscientious Objection in Nursing: Regulations and Practice in two European Countries *Nursing Ethics* [online] 27 (1) 168-183
Available from https://doi.org/10.1177/0969733019845136
[Accessed 20/10/2023]

DoH (2016) *Proposals for Changing the System of Midwifery Supervision in the UK* 22/01/2016 [online]
Available from https://www.gov.uk/government/publications/changes-to-midwife-supervision-in-the-uk/proposals-for-changing-the-system-of-midwifery-supervision-in-the-uk
[Accessed 12/06/2023]

Dollah, S., Abduh, A. and Rosmaiadewi, R. (2017) Benefits and Drawbacks of NVivo QSR Application *Advances in Social Science, Education and Humanities Research ICEST Conference* [online] 149 (2017) 61-63
Available from http://dx.doi.org/10.2991/icest-17.2017.21
[Accessed 20/10/2023]

Doyle S. (2007) Member Checking with Older Women: a Framework for Negotiating Meaning *Health Care Women International* [online] 2007 Nov-Dec 28 (10) 888-908
Available from https://doi.org/10.1080/07399330701615325
Accessed 07/05/2024

Duffey, M.K. (2008) Ethics of Conscientious Objection In: Kurtz, L. (ed.) *Encyclopaedia of Violence, Peace and Conflict* [online] 2nd ed. p.426-433, UK: Academic Press
Available from https://doi.org/10.1016/B978-012373985-8.00037-4
(https://www.sciencedirect.com/science/article/pii/B9780123739858000374)
[Accessed 26/10/2023]

Dukas, H. And Hoffman, B. (1981) *Albert Einstein, The Human Side: Glimpses from His Archives by Albert Einstein* [online] USA: Princeton University Press,
Available from https://www.jstor.org/stable/j.ctt3fgz9k
[Accessed 21/10/2023]

Eatough, V. and Smith, J. A. (2008) Interpretative Phenomenological Analysis. In Willig, C. and Stainton-Rogers, W. (Eds.) *The Sage Handbook of Qualitative Research in Psychology* [online] 1st edition (pp. 179-194) Los Angeles: Sage Publications
Available from https://doi.org/10.4135/9781848607927.n11
[Accessed 20/10/2023]

Eatough, V. & Smith, J. (2017) Interpretative Phenomenological Analysis. In: Willig, C. and Stainton-Rogers, W. (Eds.) *The SAGE Handbook of Qualitative Research in Psychology* [online] 2nd edition (pp. 193-209). USA: Sage Publications
Available from https://doi.org/10.4135/97815264055552
[Accessed 20/10/2023]

Edward, G. and De Ridder, W. (2011) The Philosophical Reactionaries: 'The Modern Sophists' In: Newman, S. (eds) Stirner, M. *Critical Explorations in Contemporary Political Thought Series* [online] UK: Palgrave Macmillan

Available from https://doi.org/10.1057/9780230348929_5
[Accessed 20/10/2023]

Elliott, R., Fischer, C.T. and Rennie, D.L. (1999) Evolving Guidelines for Publication of Qualitative Research Studies in Psychology and Related Fields *British Journal of Clinical Psychology* [online] 38 (3) 215-29
Available from https://doi.org/10.1348/014466599162782
[Accessed 20/10/2023]

Emiliussen, J., Engelsen, S., Christiansen, R. and Klausen, S. H. (2021). We are all in it! Phenomenological Qualitative Research and Embeddedness *International Journal of Qualitative Methods* [online] 20 (2021) 1-6
Available from https://doi.org/10.1177/1609406921995304
[Accessed 20/10/2023]

Engward, H. and Goldspink, S. (2020) Lodgers in the House: Living with the Data in Interpretive Phenomenological Analysis Research *Reflective Practice* [online] 21 (1) 1-13
Available from https://doi.org/10.1080/14623943.2019.1708305
[Accessed 20/10/2023]

Erdman, J. (2017) Theorizing Time in Abortion Law and Human Rights, *Health and Human Rights* [online] 19 (1) 29-40
Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5473036/
[Accessed 12/11/2020]

Fahy, K. (2002) Reflecting on Practice to Theorise Empowerment for Women: Using Foucault's Concepts, *The Australian Journal of Midwifery,* 15 (1) pgs. 5-13 [online]
Available from https://doi.org/10.1016/S1445-4386(02)80017-9.
(https://www.sciencedirect.com/science/article/pii/S1445438602800179)
Accessed 20/05/2024

Fernandez-Lynch, H. (2008) *Conflicts of Conscience in Healthcare: An Institutional Compromise* MIT Press, USA: Cambridge, Massachusetts

Fiala, C. and Arthur, J. (2014) Dishonourable Disobedience: Why Refusal to Treat in Reproductive Healthcare is Not Conscientious Objection Woman *Psychosomatic - Gynaecological Obstetrics* [online] 1 (2014) 12-23
Available from https://doi.org/10.1016/j.woman.2014.03.001
[Accessed 20/10/2023]

Fiala, C and Aurthur, J. (2017) There is No Defence for Conscientious Objection in Reproductive Healthcare *European Journal of Obstetrics, Gynaecology and Reproductive Biology* [online] 216 (Sept 2017) 254 – 8
Available from https://doi.org/10/1016/j.ejogrb2017.07.023
[Accessed 20/10/2023]

Figure 1:
Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) Diagram [online image]
Lockwood, C., Munn, Z. and Porritt, K. (2015)
Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal Evidence Based Healthcare* 13 (3) 179–187
Available from https://jbi.global/sites/default/files/2021-10/Checklist_for_Qualitative_Research.docx
[Accessed: 08/09/2020]

Figure 2:
A Hermeneutic Circle Showing the Literature Review Process [online image]
(Boell, S. K. and Cecez-Kecmanovic, D. (2014) A Hermeneutic Approach for Conducting Literature Reviews and Literature Searches *Communications of the Association for Information Systems* [online], 32 (2014), 257-286, p.264
Available from https://doi.org/10.17705/1CAIS.03412
or https://www.researchgate.net/publication/263580752
[Accessed 20/10/2023]

Figure 3:
One Example [online multimedia]
Giubilini, A. and Savulescu, J. (2020) Beyond Money: Conscientious Objection in Medicine as a Conflict of Interests. *Bioethical Inquiry* [online], 17: 229–243, p.230
Available from https://doi.org/10.1007/s11673-020-09976-9

[Accessed 20/10/2023]

Figure 4:
Heinz Dilemma by Kohlberg (1958)
In: McCleod, S. (2013) Kohlberg's Stages of Moral Development [online multimedia]
Available from www.simplepsychology.org/kohlberg
[Accessed 04/04/2022]

Figure 5:
The Violinist's Dilemma by Jarvis-Thomson (1971)
In: Matthias, A. (2020) Abortion: The Unconscious Violinist Argument Judith Jarvis Thomson: A Defense of Abortion [online] *Daily Philosophy*
Available from https://www.daily-philosophy.com/thomson-abortion-violinist-argument/
[Accessed 26/10/2023]

Figure 6:
Integrated Model of Patient Care [online image]
Varkey B. (2021) Principles of Clinical Ethics and Their Application to Practice *Med Principles of Practice* [online], 30 (1), 17-28, p.18
Available from https://doi.org/10.1159/000509119 The final, published version of this article is available at https://www.karger.com/10.1159/000509119
[Accessed 21/10/2023]

Figure 7:
Model of Conventional and alternative approaches to conscience and participation in abortion care [online image]
Czarnecki, D. Anspach RR., De Vries, RG., Dunn, MD, Hauschildt, K. and Harris LH. (2019) Conscience Reconsidered: The Moral Work of Navigating Participation in Abortion Care on Labor and Delivery. *Social Sciences Medicine* [online], 232 (2019), 181-189, p.187
Available from https://doi.org/10.1016/j.socscimed.2019.03.034 Epub 23/03/2019
[Accessed 20/10/2023]

Figure 8:
Philosophical Underpinnings of IPA

In: Condliffe, E. (2023) ‘Out of sight, out of mind’: an interpretative phenomenological analysis of young people’s experience of isolation rooms/booths in UK mainstream secondary schools, Emotional and Behavioural Difficulties [online]
Available from https://www.tandfonline.com/doi/abs/10.1080/13632752.2023.2233193
[Accessed 26/10/2023]

Figure 9:
Double Hermeneutic Loop [online image]
In: Harris, R. (2020)
Available from https://wwwyourheroicjourney.com/the-hermeneutic-foundation-of-the-heros-journey-2/
[Accessed 26/10/2023]

Figure 10:
The Iterative Process [online image]
Finlay, L. (2014) Engaging Phenomenological Analysis [online] *Qualitative Research in Psychology*, 11 (2), 121-141, p.175
Available from https://doi.org/10.1080/14780887.2013.807899
[Accessed 20/10/2023]

Figure 11:
The Blessed at the Gate to Heaven with St. Peter by Hans Memling [online image] (1466-147)
Available from
https://commons.wikimedia.org/wiki/File:Das_J%C3%BCngste_Gericht_(Memling).jpg
[Accessed 26/10/2023]

Finch, L. (2004) Understanding Patients’ Lived Experiences: the Interrelation of Rhetoric and Hermeneutics *Nursing Philosophy* [online] 5 (2004) 251–7
Available from https://doi.org/10.1111/j.1466-769X.2004.00181.x
[Accessed 20/10/2023]

Finer, L. and Fine, J.B. (2013) Abortion Law Around the World: Progress and Pushback. American Journal of Public Health. 2013 Apr;103 (4): 585-9 Available from https://www.doi.org/ 10.2105/AJPH.2012.301197
Epub 2013 Feb 14 [Accessed 03/05/2024]

Fink, L. R., Stanhope, K., Rochat, R. Bernal, O. (2016) The Fetus Is My Patient Too; Attitudes towards Abortion and Referral Amongst Physicians Conscientious Objectors in Bogota, Colombia *International Perspectives on Sexual and Reproductive Health* [online] 42 (2) 71-80
Available from https://doi.org/10.1363/42e1016
[Accessed 20/10/2023]

Finlay, L. (1998) Reflexivity: An Essential Component for All Research? *British Journal of Occupational Therapy* [online] 61(10) 453-456
Available from https://doi.org/10.1177/030802269806101005
[Accessed 22/10/2023]

Finlay, L. (2005) Reflexive Embodied Empathy: A Phenomenology of Participant-Researcher Intersubjectivity *The Humanistic Psychologist* [online] 33 (4) 271-292
Available from https://doi.org/epdf/10.1207/s15473333thp3304_4
[Accessed 24/10/2023]

Finlay L. (2008) A Dance Between the Reduction and Reflexivity: Explicating the "Phenomenological Psychological Attitude" *Journal of Phenomenological Psychology* [online] 39 (1) 1-32
Available from https://doi.org/10.1163/156916208X311601
[Accessed 20/10/2023]

Finlay, L. (2013) Unfolding the Phenomenological Research Process: Iterative Stages of "Seeing Afresh" *Journal of Humanistic Psychology* [online] 53 (2) 172–201
Available from https://doi.org/10.1177/0022167812453877
[Accessed 18/10/2023]

Finlay, L. (2014) Engaging Phenomenological Analysis *Qualitative Research in Psychology* [online] 11 (2) 121-141
Available from https://doi.org/10.1080/14780887.2013.807899
[Accessed 20/10/2023]

Fleming, V., Frith, L., Luyben, A. and Ramsayer, B. (2018) Conscientious Objection to Participation in Abortion by Midwives and Nurses: A Systematic Review of Reasons. *BMC Medical Ethics* [online] Epub. 27/04/2018; 19 (1) 31
Available (online) from https://doi.org/10.1186/s12910-018-0268-3

[Accessed 20/10/2023]

Fleming, V. and Y. Robb (2019) Potential Conflicts in Midwifery Practice Regarding Conscientious Objection to Abortions in Scotland *Midwifery* [online] 26 (2) 564-575
Available from https://doi.org/10.1177/0969733017708332
[Accessed 20/10/2023]

Fleming, V. Frith, L. and Ramsayer, B. (2019) Tensions Between Ethics and the Law: Examination of a Legal Case by Two Midwives Invoking a Conscientious Objection to Abortion in Scotland *HEC Forum* [online] 33 (3) 189-213
Available from https://doi.org/1.1007/s10730-019-09378-4
[Accessed 14/09/2019]

Fletcher, A. J. (2016) Applying Critical Realism in Qualitative Research: Methodology Meets Method *International Journal of Social Research Methodology 20* (2) pgs. 181–194 [online]
Available from https://doi.org/10.1080/13645579.2016.1144401
Accessed 29/05/2024

Fox, N.J. (2012) *The Body* UK: Blackwell Publishing

Frank, G. (1997) Is There Life after Categories? Reflexivity in Qualitative Research. *The Occupational Therapy Journal of Research* [online] 17 (2) 84-98
Available from https://doi:10.1177/153944929701700203
[Accessed 20/10/2023]

Frank, A.W. (2005) What is Dialogical Research, and Why Should We Do It?, Keynote Address, Sixth International Advances in Qualitative Methods Conference, *Qualitative Health Research,* September 2005 15 (7) pgs. 964-974 [online]
Available from http://doi:10.1177/1049732305279078
Accessed 23/05/2024

Fry, S.T. and Duffy, M.E. (2001) The Development and Psychometric Evaluation of the Ethical Issues Scale *Journal Nursing Scholarship* [online] 33 (3) 273-7
Available from https://doi.org/10.1111/j.1547-5069.2001.00273.x.
[Accessed 20/10/2023]

Fry, S.T. and Johnstone, M.J. (2008) *Ethics in Nursing Practice: A Guide to Ethical Decision-making* 3rd ed. Oxford Wiley Press, U.K. [online]
Available from https://www.researchgate.net/publication/269097490
[Accessed 29/10/2023]
In: Wicclair, M. (2011) *Conscientious Objection in Healthcare: An Ethical Analysis* USA: Cambridge University Press
Available from https://doi.org/10.1017/CBO9780511973727
[Accessed 26/10/2023]

Gadamer, H.G. (1975) Wahrheit und Methode: Grundzüge einer philosophischen Hermeneutik (Truth and Method) [online]
Available from
https://archive.orgdetails/wahrheitundmetho0000gada/page/n561/mode/2up
[Accessed 24/10/2023]

Gardiner, P. (2003) A Virtue Ethics Approach to Moral Dilemmas in Medicine *Journal Medical Ethics* [online] 29 (5) 297–302
Available from https://doi.org/10.1136/jme.29.5.297
[Accessed 20/10/2023]

Gensler, H. J. (1986) A Kantian Argument against Abortion. Philosophical Studies: An *International Journal for Philosophy in the Analytic Tradition* [online] 49 (1) 83–98
Available from http://www.jstor.org/stable/4319811
[Accessed 20/10/2023]

Gill, M. J. (2014) The Possibilities of Phenomenology for Organizational Research. *Organizational Research Methods* [online] 17 (2) 118–137
Available from https://doi.org/10.1177/1094428113518348
[Accessed 20/10/2023]

Gilligan, C. (1982) *In A Different Voice – Psychological Theory and Women's Development* USA: Harvard University Press

Gillman, L. and Lloyd, C. (2015) *Reframing Midwifery Supervision: A Discussion Paper*, London, RCM [online]
Available from https://doi.org/10.13140/RG.2.1.1254.6162
[Accessed 20/10/2023]

Gillon, R. (1994) Medical Ethics: Four Principles Plus Attention to Scope *British Medical Journal* [online] 16/07/1994; 309 (6948)184-8
Available from https://doi.org/10.1136/bmj.309.6948.184
[Accessed 20/10/2023]

Gil-Rodriguez, E. (2022) *IPA Study Survival Guide* [online]
Available from https://www.doctorelenagr.com
[Accessed 02/03/2022]

Giorgi, A. (2010) Phenomenology and the Practice of Science *Existential Analysis* [online] 21 (1) 3–22
Available from https://psycnet.apa.org/record/2010-03570-001
[Accessed 26/10/2023]

Giubilini, A. (2014) The Paradox of Conscientious Objection and the Anaemic Concept of 'Conscience': Downplaying the Role of Moral Integrity in Healthcare *Kennedy Institute of Ethics Journal* [online] 24 (2) 159-85
Available from https://doi.org/10.1353/ken.2014.0011
[Accessed 20/10/2023]

Giubilini, A. and Savulescu, J. (2020) Beyond Money: Conscientious Objection in Medicine as a Conflict of Interests *Bioethical Inquiry* [online] 17: 229–243 (2020)
Available from https://doi.org/10.1007/s11673-020-09976-9
[Accessed 20/10/2023]

Giubilini, A. (2021) Conscience In: Zalta, E.N. and Nodelman, U. (eds.) *The Stanford Encyclopaedia of Philosophy* [online] p.1-10 Winter 2019 Edition
Available from https://plato.stanford.edu/archives/win2019/entries/giubilini-conscience
[Accessed 13/02/2022]

Glaser, B.G. and Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research* [online] Chicago: Aldine
Available from https://doi.org:10.4324/9780203793206
[Accessed 20/10/2023]

Glick, S. and Jotkowitz, A. (2017) Response to: 'Why Medical Professionals Have No Moral Claim to Conscientious Objection - Accommodation in Liberal Democracies' by Schuklenk and Smalling *Journal of Medical Ethics* [online] 43 (4) 248-249
Available from https://doi.org/10.1136/medethics-2016-103670 Epub 06/09/2016
[Accessed 20/10/2023]

Goldspink, S. and Engward, H. (2018)Booming Clangs and Whispering Ghosts: Attending to the Reflexive Echoes in IPA Research. *Qualitative Research in Psychology* [Advance online publication]
Available from http://doi:10.1080/14780887.2018.1543111
Accessed 23/05/2024

Gómez-Lobo A. (2004) Does Respect for Embryos Entail Respect for Gametes? *Theoretical Medical Bioethics* [online] 25 (3) 199-208
Available from https://doi.org/10.1023/b:meta.0000040038.52317.08
[Accessed 20/10/2023]

Gorelick, S. (1991). Contradictions of Feminist Methodology. *Gender and Society 5* (4) pgs. 459–477 [online]
Available from http://www.jstor.org/stable/190095
Accessed 23/05/2024

Grace, J. D. and Priest, H. (2015) Ontology to Outcome: A Critical Analysis of Psychology Research *The Journal of Critical Psychology, Counselling and Psychotherapy,* 15 (4) pgs. 204-213 [online]
Available from
https://www.egalitarianpublishing.com/JCPCP/2015/JCPCP_v15_i04_Grace&Priest.pdf
Accessed 28/05/2024

Graham, D. (1997) “Heraclitus’ Criticism of Ionian Philosophy.” Oxford Studies in Ancient Philosophy 15 (1997): 1-50 [online]
Available from https://iep.utm.edu/heraclit
Accessed 7/05/2024

Grisez, G. (1978) Against Consequentialism, *The American Journal of Jurisprudence* [online] 23 (1) 21–72
Available from https://doi.org/10.1093/ajj/23.1.21

[Accessed 20/10/2023]

Guillen, G. D. and Rodríguez-Senden JJ. (2009) Ethics of Conscientious Objection. Madrid: *Health Sciences Foundation* p. 5 In: Toro-Flores, R., Bravo-Agüi, P., Catalán-

Gómez, M.V. et al. (2017) Opinions of Nurses Regarding Conscientious Objection *Nursing Ethics* [online] 26 (4) 1027-1038
Available from https://doi.org/10.1177/0969733017731915
[Accessed 20/10/2023]

Haddad, L.M. and Geiger, R.A. (2021) Nursing Ethical Considerations [online] [Updated 2023 Aug 14] In: *StatPearls* [online] Treasure Island (FL): StatPearls Publishing; 2023 Jan.
Available from: https://www.ncbi.nlm.nih.gov/books/NBK526054/
[Accessed 20/10/2023]

Hameed W, Azmat SK, Ali M, Sheikh MI, Abbas G, et al. (2014) Women's Empowerment and Contraceptive Use: The Role of Independent versus Couples' Decision-Making, from a Lower Middle Income Country Perspective. *PLoS ONE* 9 (8): e104633.
Available from https://doi:10.1371/journal.pone.0104633
[Accessed 20/05/2024]

Harmon, S. (2016) Abortion and Conscientious Objection: Doogan – A Missed Opportunity for an Instructive Rights-based Analysis *Medical Law International* [online] 16 (3-4) 143-173
Available from https://doi.org/10.1177/0968533216677765
[Accessed 20/10/2023]

Harney, B. and Collings, D. G. (2021) Navigating the Shifting Landscapes of HRM *Human Resource Management Review* [online] 31 (4) 100824
Available from https://doi.org/10.1016/j.hrmr.2021.100824 or (https://www.sciencedirect.com/science/article/pii/S1053482221000036)
[Accessed 20/10/2023]

Harp, D., Loke, J. and Bachmann, I. (2018) Feminist Approaches to Media Theory and Research Palgrave Macmillan Cham, [online]

Available from https://doi.org/10.1007/978-3-319-90838-0
[Accessed 23/05/2024]

Harris, L.F., Awoonor-Williams JK, Gerdts C, Gil Urbano L, González Vélez AC, Halpern J, Prata, N. and Baffoe P. (2016) Development of a Conceptual Model and Survey Instrument to Measure Conscientious Objection to Abortion Provision. *PLoS One* [online] Epub. 13/10/2016; 11 (10) e0164368
Available (online) from https://doi.org/10.1371/journal.pone.0164368
[Accessed 20/10/2023]

Heera, K.C., Shrestha, M., Pokharel, N. Niraula, S.R. Pyakurel, P. and Parajuli, S.B. (2021) Women's Empowerment for Abortion and Family Planning Decision making Among Marginalized Women in Nepal: a Mixed Method Study *Reproductive Health* 18 (28) pgs. 1-11 [online]
Available from https://doi.org/10.1186/s12978-021-01087-x
[Accessed 20/05/2024]

Heidegger, M. (1927) *Being and Time.* Schmidt, D. (ed.) (2010) Trans. Stambaugh, J. Oxford, UK: SUNY Press

Heidegger, M. (2000) *Introduction to Metaphysics*. New Haven & London: Yale University Press.

Heraclitus (550 B.C.) BrainyQuote.com. Retrieved May 6, 2024, from BrainyQuote.com Web site: https://www.brainyquote.com/authors/heraclitus-quotes

Hermansson, E. and Mårtensson, L. (2011) Empowerment in the Midwifery Context—a Concept Analysis, *Midwifery,* 27 (6) pgs. 811-816 [online]
Available from https://doi.org/10.1016/j.midw.2010.08.005.
(https://www.sciencedirect.com/science/article/pii/S026661381000135X)
[Accessed 20/05/2024]

Hesse-Biber, S. N. and Leavy, P. L. (2007). *Feminist Research Practice: A Primer.* Sage Publications

Hewson B. (2001) Reproductive Autonomy and the Ethics of Abortion *Journal of Medical Ethics* [online] 27 (Suppl 2) ii10-4.

Available from https://doi.org/10.1136/jme.27.suppl_2.ii10
[Accessed 20/10/2023]

HFEA (2021) *Code of Practice* 9th ed. [online]
Available from https://www.hfea.gov.uk/about-us/news-and-press-releases/2021
[Accessed 02/06/2023]

Hollway, W., and Jefferson, T. (2013) *Doing Qualitative Research Differently: A Psychosocial Approach.* London: SAGE Publications

Hopia, Latvala, E., and Liimatainen, L. (2016) Reviewing the Methodology of an Integrative Review *Scandinavian Journal of Caring Sciences, 30* (4) pgs. 662–669. [online]
Available from https://doi.org/10.1111/scs.12327
[Accessed 15/05/2024]

Horrigan-Kelly, M., Millar, M. and Dowling, M. (2016) Understanding the Key Tenets of Heidegger's Philosophy for Interpretive Phenomenological Research *International Journal of Qualitative Methods* [online] 15 (1) 1-8
Available from https://doi.org/10.1177/1609406916680634
[Accessed 20/10/2023]

Hochschild, A.R. (2003) *The Managed Heart.* University of California Press Ltd, London

Hughes, J.A. (2015) Conscientious Objection in Healthcare: Why Tribunals Might Be the Answer *Journal of Medical Ethics* 41 (4) 213-217
Available from https://doi.org/10.1136/medethics-2015-102970
[Accessed 30/12/2019]

Husserl, E (1907) *Thing and Space*: Lectures Of 1907 (Husserliana: Edmund Husserl - Collected Works) cited in Smith, Flowers, and Larkin (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*, 1st ed. USA: Sage Publications

Husserl, E. (1900) *Logical Investigations* Cited in Smith, Flowers, and Larkin (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*, 1st ed. USA: Sage Publications

Husserl, E. (1927) Phenomenology, Husserl, E. *The Encyclopaedia Britannica (1927):* New Complete (Trans. Palmer, R.E.) Cited in Smith, Flowers, and Larkin (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*, 1st ed. USA: Sage Publications

Ibrahim, S.M.K. (2008) *The Moral and Legal Status of the Human Fetus: A Critical Analysis from an Islamic Perspective* [online] PhD thesis, Lancaster University
Available from https://eprints.lancs.ac.uk or https://ethos.bl.uk/525340
[Accessed 30/09/2020]

International Confederation of Midwives (2024) International Code of Ethics for Midwives [online]
Available from www.internationalmidwives.org/ assets/files/general-files/2024/10/eng-international-code-of-ethics-for-midwives.pdf
[Accessed 20/05/2024]

Irwin, T. (1990) *Aristotle's First Principles*. UK, Oxford: Clarendon cited in Morgan (2013) The Potentiality Principle from Aristotle to Abortion. *Current Anthropology* [online] 54 (S7) S15–S25
Available from https://doi.org/10.1086/670804
[Accessed 26/10/2023]

Jarvis-Thomson, J. (1971) A Defense of Abortion *Philosophy and Public Affairs* [online] Autumn 1971; 1 (1) 47-66 USA: Blackwell Publishing
Available from http://www.jstor.org/stable/2265091
[Accessed 20/10/2023]

Jeong, H. and Othman, J. (2016) Using Interpretative Phenomenological Analysis from a Realist Perspective *The Qualitative Reports* [online] 21 (3) 558-570
Available from www.researchgate.net/publication/298972470
[Accessed 20/10/2023]

Jerman, J., Jones, R.K. and Onda, T. (2016) Characteristics of US Abortion Patients in 2014 and Since 2008 [online]
Available from https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf
[Accessed 20/09/2019]

Johnston, L. (2006) Software and Method: Reflections on Teaching and Using QSR NVivo in Doctoral Research *International Journal of Social Research Methodology* 9 (5) 379-391
Available from https://doi.org/10.1080/13645570600659433
[Accessed 20/10/2023]

Jones, R. and Chiu, D. (2023) Characteristics of Abortion Patients in Protected and Restricted States Accessing Clinic-based Care 12 months prior to the Elimination of the Federal Constitutional Right to Abortion in the United States, Guttmacher Institute *Perspectives on Sexual and Reproductive Health* (University of Ottawa) [online] Epub. 11/04/2023 55 (2) 80-85
Available from https://doi.org/10.1363/psrh.12224
[Accessed 20/10/2023]

Jones-Nosacek, C. (2021) Conscientious Objection, Not Refusal: The Power of a Word. *The Linacre Quarterly* [online] 88 (3) 242-246
Available from https://doi.org/10.1177/00243639211008271
[Accessed 20/10/2023]

Kahneman, D. (2011) *Thinking Fast and Slow* USA: Farraur, Straus and Giroux
Kakilla, C. (2021) Strengths and Weaknesses of Semi-Structured Interviews in Qualitative Research: A Critical Essay [online]
Available from https://doi.org/10.20944/preprints202106.0491.v1 or https://www.researchgate.net/publication/35256566
[Accessed 20/10/2023]

Kant, I. and Wood, A. (1996). Critique of practical reason (1788) In: Gregor, M. (Ed.) *Practical Philosophy* (The Cambridge Edition of the Works of Immanuel Kant, pp. 133-272 UK: Cambridge University Press
Available from https://doi.org/10.1017/CBO9780511813306.010
[Accessed 20/10/2023]

Kaplan-Sommer, A. (2019) Shhh! Don't Tell Evangelical Supporters of Israel, but Abortion There Is Legal — and Often It's Free [online] Epub. 22/05/2019
Available from https://www.haaretz.com/israel-news/.premium.MAGAZINE-shhh-don-t-tell-evangelical-supporters-of-israel-about-the-country-s-abortion-laws-1.7274968
[Accessed 12/10/2019]

Katz, D. (2015) *Conscientious Objection and Judaism – Does One Have the Right to Conscientiously Object in Judaism?* [Lecture online]
Available from
https://www.chabad.org.uk/multimedia/video_cdo/aid/3210833/jewish/Conscientious-Objection-and-Judaism.htm
[Accessed 20/10/2019]

Keogh, L.A, Gillam, L., Bismark, M., McNamee, K., Webster, A., Bayly, C. and Newton, D. (2019) Conscientious Objection to Abortion, the Law and its Implementation in Victoria, Australia: Perspectives of Abortion Service Providers *BMC Med Ethics* [online] Epub. 31/01/2019; 20 (1) 11
Available from https://doi.org/10.1186/s12910-019-0346-1
[Accessed 20/10/2023]

Khitamy, B.A. (2013) Divergent Views on Abortion and the Period of Ensoulment. *Sultan Qaboos University Medical Journal* [online] Epub 27/02/2013; 13 (1) 26-31
Available from https://doi.org/10.12816/0003192
[Accessed 20/10/2023]

Kidder, M. and Fine. (1997) Qualitative Inquiry in Psychology: A Radical Tradition. In: Fox, D. and Prilleltensky, I. (eds.) *Critical Psychology* USA: Sage p.34-50
Available online from https://psycnet.apa.org/record/1997-08663-002
[Accessed 26/10/2023]

Kim, K. (2004) Critical Theory Criticized: Giddens's Double Hermeneutic and the Problem of Language Game Change. *Cultural Studies ↔ Critical Methodologies*, [online] 4 (1) 28–44
Available from https://doi.org/10.1177/1532708603254352
[Accessed 20/10/2023]

Kohlberg, L. (1958) *The Development of Modes of Thinking and Choice Years Ten to Sixteen* PhD thesis, University of Chicago [online]
Available from https://books.google.co.uk/books?id=StsQAQAAIAAJ
[Accessed 19/10/2023]

Kuflik, A. (2008) The Future Like Ours Argument and Human Embryonic Stem Cell Research *Journal Medical Ethics* [online] 34 (6) 417-421
Available from https://doi.org/10.1136/jme.2007.023556
[Accessed 20/10/2023]

Lamb, C, Evans, M, Babenko-Mould, Y, Wong, C. and Kirkwood, K. (2019) Nurses' Use of Conscientious Objection and the Implications for Conscience *Journal of Advanced Nursing* [online] 75: 594– 602
Available from https://doi.org/10.1111/jan.13869
[Accessed 19/20/2023]

Lamb, C. (2016) Conscientious Objection: Understanding the Right of Conscience in Health and Healthcare Practice *The New Bioethics* [online] 22 (1) 33-44
Available from https://doi.org/10.1080/20502877.2016.1151252
[Accessed 20/10/2023]

Larkin, M., Watts, S. and Clifton, E. (2006) Giving Voice and Making Sense in Interpretative Phenomenological Analysis *Qualitative Research in Psychology* [online] 3 (2) 102-120
Available from https://doi.org/10.1191/1478088706qp062oa
[Accessed 20/10/2023]

Larkin, M., and Thompson, A. (2012) Interpretative Phenomenological Analysis. In Thompson, A. and Harper, D. (Eds.) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* [online] (pp. 99-116) UK: John Wiley & Sons
Available from https://doi.org/10.1002/9781119973249 or https://www.online.wiley.com
[Accessed 20/10/2023]

Lazari-Radek, K. and Singer, P. (2014) *Point of View of the Universe – Sidgwick and Contemporary Ethics* UK: Oxford University Press

Liberati, A., Altman, D., Tetzlaff, J. Mulrow, C., Gotzsche, P., Ioannidis, J., Clarke, M., Devereaux, P., Kleijnen, J. and Moher, D. (2009) The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies that Evaluate Healthcare Interventions: Explanation and Elaboration *British Medical Journal* [online] p339 b2700 Available from https://doi.org/10.1136/bmj.b2700
[Accessed 25/11/2020]

Lincoln, Y.S. and Guba, E.G. (1985) *Naturalistic Inquiry* Newbury Park, USA, CA: Sage Publications

Lindeman, T. (2023) Canada has Zero Pro-choice Conservative MPs, Watchdog Says *The Guardian* [online] Epub. 03/08/2023 at 08.30 https://www.theguardian.com
[Accessed 30/06/2023]

Little, M. (2008) Abortion and the Margins of Personhood *Rutgers Law Journal* 39: 331–348
Available from https://www.academia.edu/14877194
[Accessed 08/10/2023]

Lockwood, C., Munn, Z. and Porritt, K. (2015) Qualitative Research Synthesis: Methodological Guidance for Systematic Reviewers Utilizing Meta-aggregation. *International Journal of Evidence Based Healthcare* 2015 Sep; 13 (3) pgs.179-87 [online]
Available from https://doi:10.1097/XEB.0000000000000062
[Accessed 15/05/2024]

Loffhagen, E. (2022) MPs have Voted to Bring in Buffer Zones in England and Wales Around Abortion Providers [online] Epub. 19/10/2022 *The Evening Standard*
Available from https://www.standard.co.uk
[Accessed 14/07/2023]

Long H.A., French D.P. and Brooks J.M. (2020) Optimising the Value of the Critical Appraisal Skills Programme (CASP) Tool for Quality Appraisal in Qualitative Evidence Synthesis. *Research Methods in Medicine & Health Sciences* [online] 1 (1) 31-42

Longino, H.E. (1987), Can There Be A Feminist Science?. *Hypatia*, 2 pgs. 51-64 [online] Available from https://doi.org/10.1111/j.1527-2001.1987.tb01341.x

[Accessed 23/05/2024]

Little, M. (2008) Abortion and the Margins of Personhood *Rutgers Law Journal* [online] (39) 331–348
Available from https://doi.org/10.1177/2632084320947559
[Accessed 20/10/2023]

Love, B., Vetere, A. and Davis, P. (2020) Should Interpretative Phenomenological Analysis (IPA) be Used With Focus Groups? Navigating the Bumpy Road of “Iterative Loops,” Idiographic Journeys, and “Phenomenological Bridges” *International Journal of Qualitative Methods* [online] 19
Available from https://doi.org/10.1177/1609406920921600
[Accessed 25/10/2023]

Mackintosh, E.K. (2014) Abortion and Moral Context: Human Beings in a Moral Community [online] PhD thesis, Durham University
Available from https://www.etheses.dur.ac.uk/11077
[Accessed 25/10/2023]

Madill, A., Flowers, P., Frost, N. and Locke, A. (2018). A Meta-methodology to Enhance Pluralist Qualitative Research: One Man’s Use of Socio-sexual Media and Midlife Adjustment to HIV. *Psychology & Health* 33 (10) pgs. 1209-1228 [online]
Available from http://doi:10.1080/08870446.2018.1475670.
[Accessed 23/05/2024]

Magelssen, M. (2012) When Should Conscientious Objection be Accepted? *Journal Medical Ethics* [online] 2012 Jan; 38 (1) 18-21
Available from https://doi.org/10.1136/jme.2011.043646 Epub 20/06/2011
[Accessed 20/10/2023]

Markowitz S. (1990) Abortion and Feminism. *Social Theory and Practice*. 1990 Spring; 16 (1) pgs.1-17 [online]
Available from https://doi:10.5840/soctheorpract19901611.
https://www.jstor.org/stable/23557071
[Accessed 23/05/2024]

Marquis, D. (1989) Why Abortion is Immoral. *The Journal of Philosophy* [online] 1989 Apr; 86 (4) 183-202
Available from https://doi.org/10.2307/2026961
[Accessed 20/10/2023]

Marquis, D. (2001) Deprivations, Futures and the Wrongness of Killing. *Journal of Medical Ethics* [online] 27 (6) 363-9
Available from https://doi.org/10.1136/jme.27.6.363
[Accessed 20/10/2023]

Marquis, D. (2002) A Defence of the Potential Future of Value Theory *Journal of Medical Ethics* [online] 28 (3) 198-201; discussion 202
Available from https://doi.org/10.1136/jme.28.3.198
[Accessed 20/10/2023]

Mauron, A. (2017) *Ethics Aspects of Reproductive Health* [online] Lecture - 8th Postgraduate Course for Training in Reproductive Medicine and Reproductive Biology
Available from
https://www.gfmer.ch/Endo/Lectures08/ethicalaspectsofreproductivehealth.htm
[Accessed 20/10/2023]

McCleod, S. (2013) Kohlberg's Stages of Moral Development [online multimedia]
Available from www.simplepsychology.org/kohlberg
[Accessed 04/04/2022]

McInally, W. and Gray-Brunton, C. (2021) Research Made Simple: Using Multi-Perspective Interpretative Phenomenological Analysis to Explore Healthcare Phenomena *Evidence-Based Nursing* [online] 24 (3) 71-73
Available from https://doi.org/10.1136/ebnurs-2021-103428
or https://ebn.bmj.com/content/ebnurs/24/3/71.full.pdf
[Accessed 20/10/2023]

McLean, E., Desalegn, D.N., Blystad, A. et al. (2019) When the Law Makes Doors Slightly Open: Ethical Dilemmas Among Abortion Service Providers in Addis Ababa, Ethiopia. *BMC Medical Ethics* [online] 20 (60) (2019)
Available from https://doi.org/10.1186/s12910-019-0396-4
[Accessed 20/10/2023]

McLean, M. (2013) Conscientious Objection by Muslim Students Startling *Journal Medical Ethics* [online] 39 (11) 708
Available from https://doi.org/10.1136/medethics-2013-101332
[Accessed 19/09/2019]

Mead, G.H. (1934) *Mind, Self, and Society from the Standpoint of a Social Behaviourist*. USA: University of Chicago Press

Megregian, M., Low, L., Emeis, C., De Vries, R. and Nieuwenhuijze, M. (2020) "I'm Sure We Talked about it": Midwives Experiences of Ethics Education and Ethical Dilemmas, A Qualitative Study *Women and Birth* [online] 33 (6) 105035
Available from https://doi.org/10.1016/j.wombi.2019.12.005
[Accessed 20/10/2023]

Menezes, G. and Aquino, E.M. (2009) Pesquisa sobre o aborto no Brasil: avanços e desafios para o campo da saúde coletiva [Research on Abortion in Brazil: Gaps and Challenges for the Public Health Field]. *Cad Saude Publica* [online] 25 (Suppl 2) S193-204. (In Portuguese)
Available from https://doi.org/10.1590/s0102-311x2009001400002
[Accessed 20/10/2023]

Merleau-Ponty, M. (1945) *Phenomenology of Perception* In: International Library of Philosophy [online multimedia]
Available from https://www.perlego.com/book/1617089
[Accessed 23/10/2023]

Mill, J.S. (1859) *On Liberty* UK: Oxford University

Minerva, F. (2015) Conscientious Objection in Italy *Journal of Medical Ethics* [online] 41 (2) 170-173
Available from https://doi.org/10.1136/medethics-2013-101656
[Accessed 20/10/2023]

Minerva, F. (2017) Conscientious Objection - Complicity in Wrong-doing and a Not So Moderate Approach *Cambridge Quarterly of Healthcare Ethics* [online] 26 (1) 109-119
Available from https://doi.org/10.1017/S0963180116000682
[Accessed 20/10/2023]

Miola, J. (2015a) Making Decisions About Decision-making: Conscience, Regulation, and the Law *Medical Law Review* [online] 23 (2) 263-82
Available from https://doi.org/10.1093/medlaw/fwv010 Epub 24/04/2015
[Accessed 20/10/2023]

Miola, J. (2015b) The Legitimacy of Medical Treatment. In: Forvargue, S. and Mullock, A. (2015) *Moralising Medicine – Proper Medical Treatment and the Role of Ethics and Law in Decision – Making* [online eBook] UK: Routledge p.18
Available from https://uat.taylorfrancis.com/chapters/edit/10.4324/9781315744308-11
[Accessed 20/09/2019]

Montague, J., Phillips, E., Holland, F. and Archer, S. (2020) Expanding Hermeneutic horizons: Working as Multiple Researchers and with Multiple Participants *Research Methods in Medicine & Health Sciences* [online] 1 (1) 25-30
Available from https://doi.org/10.1177/2632084320947571
[Accessed 20/10/2023]

Morawski, J. (2014) Reflexivity. In: Teo T. (ed.) *Encyclopaedia of Critical Psychology* p. 1653-1660 [online] USA: Springer
Available from https://doi.org/10.1007/978-1-4614-5583-7_263
[Accessed 20/10/2023]

Moreau, C., Shankar, M., Glasier, A., Cameron, S. and Gemzell-Danielsson, K. (2021) Abortion Regulation in Europe in the Era of COVID-19: a Spectrum of Policy Responses *BMJ Sexual Reproductive Health* [online] 47 (4) e14
Available from https://doi.org/10.1136/bmjsrh-2020-200724 Epub 22/10/2022
[Accessed 20/10/2023]

Morgan, L. M. (2013) The Potentiality Principle from Aristotle to Abortion *Current Anthropology* [online] 54 (S7), S15–S25
Available from https://doi.org/10.1086/670804
[Accessed 20/10/2023]

Motta, V. and Larkin, M. (2023) Absence of Other and Disruption of Self: An Interpretative Phenomenological Analysis of the Meaning of Loneliness in the Context of Life in a Religious Community *Phenomenological Cognitive Science* [online] 22 (1) 55–80 Available from https://doi.org/10.1007/s11097-022-09832-8

[Accessed 20/10/2023]

Naden, C. (2007) *Abortion* USA: Marshall Cavendish cited in Almutairi (2007) *The Relationship Between Religion and Law in The Sphere of Abortion Regulation: A Case Study of Saudi Arabia and Ireland* [online]
Available from https://www.academia.edu/35519610
Master's thesis, University of Maynooth, Ireland
[Accessed 16/06/2022]

Neal, M. (2017) *Conscientious Objection in the Era Time of Home Abortion* [online] Epub.19/12/2017
Available from https://blogs.bmj.com/bmj/2017/12/19
[Accessed 15/09/2019]

Neal, M. (2019) Conscientious Objection in Healthcare, 'Proper Medical Treatment' and Professionalism: The Limits of Accommodation for Conscience in Healthcare. In: Adenitire, J. (ed) *Religious Beliefs and Conscientious Exemptions in a Liberal State* p.135-156 USA: Cambridge University Press [online]
Available from https://pure.strath.ac.uk/ws/portalfiles/portal/85759589/
[Accessed 26/10/2023]

Nehamas, A. (1998) *Nietzsche: Life as Literature* USA: Cambridge University Press [online eBook]
Available from https://archive.org/details/nietzschelifeasl00neha_0
[Accessed 26/10/2023]

Newport, F. (2022) *Personal Religiosity and Attitudes Toward Abortion* [online] Epub. 13/05/2022
Available from www.news.gallup.com/392648
[Accessed 10/10/2023]

NHS England (2015) *Better Births - A Five year Forward View of Maternity Care National Maternity Review* [online]
Available from https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/
[Accessed 16/09/2019]

NHS England (2017) *A-EQUIP a Model of Clinical Midwifery Supervision* Publications Gateway [online] Reference Number: 06612
Available from https://www.england.nhs.uk/wp-content/uploads/2017/04/a-equip-midwifery-supervision-model
[Accessed 01/11/2022]

NHS (2021) *The NHS Constitution for England* [online]
Available from https://www.gov.uk/ government/publications/the-nhs-constitution-for-england Epub. 08/03/2012
[Accessed 12/09/2023]

Nickerson, C. (2021) *Symbolic Interactionism Theory & Examples* [online multimedia]
Available from https://simplepsychology.org/symbolic-interaction-theory.html
[Accessed 12/03/2022]

Nieminen, P., Lappalainen, S., Ristimäki, P., Myllykangas, M. and Mustonen, A.M. (2015) Opinions on Conscientious Objection to Induced Abortion Among Finnish Medical and Nursing Students and Professionals *BMC Medical Ethics* [online] Epub. 25/03/2015; 16 (17) 1-9
Available from https://doi.org/10.1186/s12910-015-0012-1
[Accessed 21/10/2023]

Nietzsche, F. (1889) *On the Genealogy of Morality* USA: Dover Thrift Editions[online eBook)
Available from https://ia601907.us.archive.org/21/items/nietzsche-on-the-genealogy-of-morality/Nietzsche
[Accessed 26/10/2023]

Nizza, I., Farr, J. & Smith, J. (2021) Achieving Excellence in Interpretative Phenomenological Analysis (IPA): Four Markers of High Quality *Qualitative Research in Psychology* [online] 18 (3) 369-386
Available from https://doi.org/10.1080/14780887.2020.1854404
[Accessed 21/10/2023]

Nolan, M. (2011) *The Experience of Living with Spinal Cord Injury in the Early Months Following Discharge from Rehabilitation: A Qualitative Study on a Male Sample* [online] Unpublished Doctoral thesis approved by Essex University

Available from https://ethos.bl.uk/uk.bl.ethos.531538
[Accessed 21/10/2023]

Noon, E.J. (2018) Interpretive Phenomenological Analysis: An Appropriate Methodology for Educational Research? *Journal of Perspectives in Applied Academic Practice* [online] 6 (1) 75-83
Available from https://doi.org/10.14297/jpaap.v6i1.304
[Accessed 06/05/2024]

Nucci, E. (2009) On How to Interpret the Role of the Future Within the Abortion Debate *Journal of Medical Ethics* [online] 35 (10) 651-652
Available from https://doi.org/10.1136/jme.2009.031294
[Accessed 20/09/2019]

Nursing and Midwifery Council (NMC) (2021) *The Code Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates* [online]
Available from https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
or https://www.nmc.org.uk/standards/code
[Accessed 12/09/2023]

O'Sullivan, S. and Pecorino, P. (2002) Relativism In: *Ethics Online Textbook* [online multimedia, Section 3, USA: City Merlo University
Available from https://www.qcc.cuny.edu/SocialSciences/ppecorino/ETHICS_TEXT/Chapter_3_Relativism/Relativism_Types.htm
[Accessed 01/05/2022]

Odell, J., Abhyankar, R., Malcolm, A. and Rua, A. (2014) *Conscientious Objection in the Healing Professions: A Readers' Guide* [online multimedia]
Available from www.corr.ac.uk/download.poderbergdf/46958598.pdf
[Accessed 07/06/2014]

Oderberg, D. (2018) Guest Post: The Conscientious Objection (Medical Activities) Bill: Some Objections Rebutted *Journal of Medical Ethics* [online]
Available from https://www.blogs.bjm.com/medical-ethics/ /2018/03/16/guest-post-the-conscientious-objection-medical-activities-bill-some-objections-rebutted/ Epub. 16/03/2018

[Accessed 22/10/2023]

Office of National Statistics (2021) *Abortion Statistics* [online]
Available from https://www.ons.gov.uk/ government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021
[Accessed 30/06/2023]

Orr, R. (2007) The Role of Moral Complicity in Issues of Conscience *American Journal of Bioethics* [online] 7(12) 123-124
Available from https://doi.org/10.1080/15265160701710014
[Accessed 21/10/2023]

Ortiz-Millán, G. (2017) Abortion and Conscientious Objection: Rethinking Conflicting Rights in the Mexican Context *Global Bioethics* [online] 29 (1) 1–15
Available from https://doi.org/10.1080/11287462.2017.1411224
[Accessed 21/10/2023]

O'Shea, T. (2018) Modern Moral Conscience *Journal of Medical Ethics* [online] 43 (1) 56-59
Available from https://doi.org/10.1080/09672559.2018.1497074
[Accessed 21/10/2023]

Oxley, L. (2016) An Examination of IPA *Education and Child Psychology* [online]
Available from https://explore.bps.org.uk/content/bpsecp/33/3/55
Accessed 23/05/2024

Page, K. (2012) The Four Principles: Can They be Measured and Do They Predict Ethical Decision-making? *BMC Medical Ethics* [online] Epub. 20/03/2012; 13 (10)
Available from https://doi.org/10.1186/1472-6939-13-10
[Accessed 21/10/2023]

Palacio-Vera, H. (2020) *How Congress Can Immediately Seize on Monday's Abortion Rights Win* [online]
Available from https://www.guttmacher.org/article/2020/06/how-congress-can-immediately-seize-mondays-abortion-rights-win
[Accessed 30/06/2020]

Paré, G. and Kitsiou, S. (2017) Methods for Literature Reviews. In: Lau F, Kuziemsky C, editors. Handbook of eHealth Evaluation: An Evidence-based Approach Chapter 9 [online]. Victoria (BC): University of Victoria; 2017 Feb 27.
Available from https://www.ncbi.nlm.nih.gov/books/NBK481583/
[Accessed 16/05/2024]

Patnaik, E. (2013) Reflexivity: Situating the Researcher in Qualitative Research. *Humanities and Social Science Studies* [online] 2 (2013) 98-106
Available from www.researchgate.net/publications/263916084
[Accessed 21/10/2023]

Peat, G., Rodriguez, A. and Smith, J. (2019) Interpretive Phenomenological Analysis Applied to Healthcare Research *Evidence-Based Nursing* [online] 22 (1) 7-9
Available from https://doi.org/10.1136/ebnurs-2018-103017 or https://ebn.bmj.com/content/ebnurs/22/1/7.full.pdf
[Accessed 21/10/2023]

Pecorino, P. (2002) Rights, Truth and Consent; Presentation of Issues: Autonomy. In: *Medical Ethics Online Textbook* [online] Section 6
Available from
https://www.qcc.cuny.edu/socialsciences/ppecorino/medical_ethics_text/Chapter_6_Patient_Rights/ISSUES_AUTONOMY.htm
[Accessed 26/04/2022]

Pellegrino, E. (2002) The Physician's Conscience, Conscience Clauses and the Religious Belief: A Catholic Perspective *Fordham Urban Law Journal* [online] 30 (1) 221
Available from http://ir.lawnet.fordham.edu/ulj/vol30/iss1/13
[Accessed 21/10/2023]

Pellegrino, E. and Thomasma, D. (1988) *For the Patient's Good: The Restoration of Beneficence in Health Care* UK: Oxford University Press Thomasma, D. (ed.) [online]

Available from https://philpapers.org/rec/PELFTP
[Accessed 26/10/2023]

Pietkiewicz, I. and Smith, J. (2014). A Practical Guide to Using Interpretative Phenomenological Analysis in Qualitative Research Psychology *Czasopismo Psycologiczne Psychological Journal* [online] 20 (2014) 7-14
Available from https://doi.org/10.14691/CPPJ.20.1.7
[Accessed 21/10/2023]

Pluye, P., Grad, R., Levine, A. & Nicolau, B. (2009) Understanding Divergence of Quantitative and Qualitative Data (or results) in Mixed Methods Studies *International Journal of Multiple Research Approaches* [online] 3 (1) 58-72
Available from https://doi.org/10.5172/mra.455.3.1.58
[Accessed 22/10/2023]

Polit, D.F. and Beck, C.T. (2014) *Essentials of Nursing Research: Appraising Evidence for Nursing Practice* 8th Edition USA: Lippincott Williams & Wilkins, Philadelphia

Price K. (2011) It's Not Just About Abortion: Incorporating Intersectionality in Research About Women of Color and Reproduction. *Womens Health Issues*. 2011 May-Jun; 21 (3 Suppl) pgs. S55-7 [online]
Available from https://doi:10.1016/j.whi.2011.02.003
Accessed 23/05/2024

Pringle, J., Drummond, J., McLafferty, E. and Hendry, C. (2011) Interpretative Phenomenological Analysis: A Discussion and Critique *Nurse Researcher* [online] 18 (3) 20-4
Available from https://doi.org/10.7748/nr2011.04.18.3.20.c8459
[Accessed 21/10/2023]

Quinn, P. L. (1995) Political Liberalisms and Their Exclusions of the Religious. *Proceedings and Addresses of the American Philosophical Association* [online] 69 (2) 35–56
Available from https://doi.org/10.2307/3130495
[Accessed 21/10/2023]

Quinn, C. and Clare, L. (2008) Interpretative Phenomenological Analysis. In: McKenna, W. R. Cowman, H. and Skeady, J. (eds) *Nursing Research Designs and Methods* [online] p.375-384, UK: Churchill Livingstone Elsevier
Available from https://www.researchgate.net/publication/279956773

[Accessed 25/10/2023]

Rahman, A., Katzive, L. and Henshaw, S.K. (1998) A Global Review of Laws on Induced Abortion, 1985–1997" International Family Planning Perspectives 24, no. 2 (1998): 56–64 p.60
Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673257/#bib5
[Accessed 03/05/2024]

Ramsayer, B. and Fleming, V. (2020) Conscience and Conscientious Objection: The Midwife's Role in Abortion Services *Nursing Ethics* [online] 27(8) 1645-1654
Available from https://doi.org/10.1177/0969733030928416
[Accessed 21/10/2023]

Raphael, D. (2007) *The Impartial Spectator: Adam Smith's Moral Philosophy* UK: OU Press, p.32-42, [online eBook] Oxford Scholarship Online
Available from https://doi.org/10.1093/acprof:0s0/9780199213337.001.0001
[Accessed 21/10/2023]

Rawls, J. (1993) *Political Liberalism* Colombia University Press, Colombia, USA Readers' Guide to the Ethical and Social Issues [online eBook]
Available from https://www.perlego.com/book/775602/political-liberalism
[Accessed 21/10/2023]

Rawls, J. (1999) *A Theory of Justice* USA: Harvard University Press [online eBook]
Available from https://doi.org/10.2307/j.ctvkjb25m
[Accessed 21/10/2023]

Rawls, J. (2005) *Political Liberalism* (Expanded Version) USA: Columbia University Press [online eBook]
Available from https://www.jstor.org/stable/10.7312/rawl13088
[Accessed 21/10/2023]

Redman, S., Greenhalgh, T., Adedokun, L. and Denegri, S. (2021) Co-production of Knowledge: The Future *British Medical Journal* [online] 372:n434
Available from https://doi.org/10.1146/bmj.n434 or
https://www.bmj.com/content/372/bmj.n434.long

[Accessed 21/10/2023]

Regan, L. and Glasier A. (2017) The British 1967 Abortion Act - Still Fit for Purpose? *The Lancet* [online] Epub. 208/08/2017; 390 (10106) 1936-1937
Available from https://doi.org/10.1016/S0140-6736(17)32753-8 Epub 26/10/2017
[Accessed 21/10/2023]

Reid, K., Flowers, P. and Larkin, M. (2005) Exploring Lived Experience *The Psychologist* [online] 18 (1) 20-23
Available from https://www.psychnet.apa.org/2005-02203-005
[Accessed 21/10/2023]

Rettie, H. and Emiliussen, J. (2019) Practical Impressions of Interpretative Phenomenological Analysis from the Novice's Standpoint *Nurse Researcher* [online] Epub. 21/09/2019; 26 (2) 46-49
Available from https://doi.org/10.7748/nr.2018.e1589 Epub 11/09/2018
[Accessed 21/10/2023]

Richards, J. (1997) Too Choosy About Choice? *British Journal of Midwifery* [online] 5 (3) 163 -167
Available from https://doi.org/10.12968/bjom.1997.5.3.163
[Accessed 21/10/2023]

Ricœur, P. (1975) *The Rule of Metaphor: Multi-Disciplinary Studies of the Creation of Meaning in Language*, trans. Czerny, R. with McLaughlin, K. and Costello, J. UK: Routledge [1975], p.4 [online eBook]
Available from https://archive.org/details/ruleofmetaphormu0000ricu
[Accessed 26/10/2023]

Ricœur, P. (1984) *Time and Narrative*, vol. 1, McLaughlin, K. and Pellauer, D. (trans.), USA: University of Chicago Press p. 109 [online eBook]
Available from https://press.uchicago.edu/ucp/books/book/chicago/T/bo5962044
[Accessed 25/10/2023]

Riley, R. and Weiss, M.C. (2016) A Qualitative Thematic Review: Emotional Labour in Healthcare Settings. *Journal of Advanced Nursing* 72 (1) pgs.6–17 [online]
Available from https://onlinelibrary.wiley.com/doi/epdf/10.1111/jan.12738

Accessed 21/05/2024

Roberts, T. (2013) Understanding the Research Methodology of Interpretative Phenomenological Analysis *British Journal of Midwifery* [online] Epub.16/08/2013; 21(3) 215-218
Available from https://doi.org/10.12968/bjom.2013.21.3.215
[Accessed 21/10/2023]

Romanis, E.C. (2020a) Challenging the 'Born Alive' Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood *Medical Law Review* [online] Epub. 01/02/2020; 28 (1) 93-123
Available from https://doi.org/10.1093/medlaw/fwz014
[Accessed 21/10/2023]

Romanis, EC. (2020b) Is 'Viability' Viable? Abortion, Conceptual Confusion and the Law in England and Wales and the United States *Journal of Law and Biosciences* [online] Epub. 09/10/2020; 7 (1) lsaa059
Available from https://doi.org/10.1093/jlb/lsaa059
[Accessed 21/10/2023]

Romanis, E. C. and Parsons, J. A. (2020) Legal and Policy Responses to the Delivery of Abortion Care During COVID-19 *International Journal of Gynaecology and Obstetrics* [online] 151 (3) 479-486
Available from https://doi.org/10.1002/ijgo.13377
[Accessed 21/10/2023]

Royal College of Nursing (RCN) 2019) *Termination of Pregnancy: Conscientious Objection* [online]
Available from https://www.rcn.org.uk/clinical-topics/Womens-health/Termination-of-pregnancy/Termination-of-pregnancy-conscientious-objection
[Accessed 14/09/2019]

R[oyal College of Nursing (2023) *Duty of Care* [online multi-media]
Available from https://www.rcn.org.uk/Get-Help/RCN-advice/duty-of-care
[Accessed 19/05/2024]

Royal College of Obstetricians and Gynaecologists (RCOG) (2011) *The Care of Women Requesting Induced Abortion*, Evidence – based Clinical Guideline Number 7 [online] Available from https://www.rcog.org.uk/ guidance/browse-all-guidance/other-guidelines-and-reports/the-care-of-women-requesting-induced-abortion-evidence-based-clinical-guideline-no-7/
[Accessed 23/09/2023]

Roy, A. and Oludaja, B. (2009) Hans-Georg Gadamer's Praxis*:* Implications for Connection and Action in Communication Studies *Communication, Culture and Critique* [online] Epub. 01/09/2009; 2 (3) 255-273
Available from https://doi.org/10.1111/j.1753-9137.2009.01038.x
[Accessed 25/10/2023]

Rutty, J.E. (2016) Religious Attitudes to Death In: Rutty, G.N. (eds.) *Encyclopaedia of Forensic & Legal Medicine* [online] p.1-22, 2nd ed. UK: Elsevier Publishing
Available from https://doi.org/10.1007/978-1-4471-0699-9_1
[Accessed 21/10/2023]

Saad, T.C. (2019) Conscientious Objection: Unmasking the Impartial Spectator *Journal Medical Ethics* [online] Epub. 08/10/2020; 45 (10) 677-678
Available from https://doi.org/10.1136/medethics-2019-105698
[Accessed 25/10/2023]

Safer Maternity Teams (2019) A Quick Guide to Decision-Making – Human Factors in Obstetrics [online presentation]
Available from http://youtube/lp9fJ1PAGgQ
[Accessed 03/08/2023]

Sandelowski, M.J. (2008) Justifying Qualitative Research *Research in Nursing and Health* [online] 31(3) 193-195
Available from https://doi.org/10.1002/nur.20272
[Accessed 21/10/2023]

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H. and Jinks, C. (2018) Saturation in Qualitative Research: Exploring its Conceptualization and operationalization *Qualitative Quantitative* [online] 52 (4) 1893–1907
Available from https://doi.org/10.1007/s11135-017-0574-8

[Accessed 21/10/2023]

Savell, K.L. (2007) Life and Death Before Birth: 4D Ultrasound and the Shifting Frontiers of the Abortion Debate *Journal of Law and Medicine* [online] 15 (1) 103-106, Sydney Law School Research Paper No. 08/89
Available from https://ssrn.com/abstract=1219085
[Accessed 21/10/2023]

Savulescu, J. (2001) Is Current Practice Around Late Abortion Eugenic and Discriminatory? *Journal of Medical Ethics* [online] 27 (3) 165-171
Available from https://doi.org/10.1136/jme.27.3.165
[Accessed 01/07/2020]

Savulescu, J. (2006) Conscientious Objection in Medicine *British Medical Journal* [online] Epub. 04/02/2006; 332 (7536) 294-7
Available from https://doi.org/10.1136/bmj.332.7536.294
[Accessed 21/10/2023]

Savulescu, J. and Giubilini, A. (2018) Against Conscientious Objection in Health care: A Counter Declaration and Reply to Oderberg *Practical Ethics* [online] Epub. 11/10/2018
Available from www.blogpracticalethics.ox.ac.uk
[Accessed 21/10/2023]

Scanlon, D. (1994) Ethics Survey Looks at Nurses' Experiences *The American Nurse* [online] 26 (10) 22
Available from https://repository/library.georgetown.edu/handle/10822/750374
[Accessed 21/10/2023]

Schenker, J.G. and Eisenberg, V.H. (1997) Ethical Issues Relating to Reproduction Control and Women's Health *International Journal of Gynaecology and Obstetrics* [online] 58 (1) 167-76
Available from https://doi.org/10.1016/s0020-7292(97)02866-x
[Accessed 21/10/2023]

Schleiermacher, F. (1998) *Hermeneutics and Criticism and Other Writings* (A. Bowie, Trans) [online] USA: Cambridge University Press
Available from https://doi.org//10.1017/CB09780511814945

[Accessed 21/10/2023]

Schuklenk, U. and Smalling, R. (2017) Why Medical Professionals Have No Moral Claim to Conscientious Objection: Accommodation in Liberal Democracies *Journal of Medical Ethics* [online] 43 (4) 234-240
Available from https://doi.org/10.1136/medethics-2016-103560
[Accessed 21/10/2023]

Schulenberg, U. (2015) John Dewey and the Moral Imagination p. 145-153 In: *Romanticism and Pragmatism* [online] UK: Palgrave Macmillan
Available from https://doi.org/10.1057/9781137474193_11
[Accessed 21/10/2023]

Self, B. (2021) Conducting Interviews During the Covid-19 Pandemic and Beyond FQS [online] 29/09/2021 22 (3) (2021)
Available from https://researchonline.ljmu.ac.uk/id/eprint/15670/3
[Accessed 21/10/2023]

Self, B. (2023) U.K. Service-Users' Experiences of and Views on Healthcare Practitioners' Right to Conscientiously Object to Abortion [online] PhD thesis, Liverpool John Moores University
Available from http://www.researchonline.ljmu.ac.uk/id/eprint/21637
http://doi:10.24377/LJMU.t.00021637
[Accessed 01/10/2023]

Self, B., Maxwell, C. and Fleming, V. (2023) The Missing Voice in the Conscientious Debate: British Service-users Experiences of Conscientious Objection *BMC Medical Ethics* [online] 24, 65 (2023)
Available from https://doi.org/10.1186/s12910-023-00934-9
[Accessed 21/10/2023]

Serour, G. (2013) Ethical Issues in Human Reproduction – Islamic Perspectives *Gynaecology Endocrinology* [online] 29 (11) 949 – 52
Available from https://doi.org/10.3109/09513590.2013/825714
[Accessed 21/10/2023]

Shahvisi, A. (2018) Conscientious Objection: A Morally Insupportable Misuse of Authority *Clinical Ethics* [online] 13 (2) 82-87
Available from https://doi.org/10.1177/1477750917749945
[Accessed 22/10/2023]

Shanawani, H. (2016) The Challenges of Conscientious Objection in Health care. *Journal of Religion and Health* [online] 55 (2) 384-93
Available from https://doi.org/10.1007/s10943-016-0200-4
[Accessed 21/10/2023]

Shaw, D.M. (2011) Justice and the Fetus: Rawls, Children, and Abortion *Cambridge Quarterly of Healthcare Ethics* [online] 20 (01) 93-101
Available (online) from http://eprints.gla.ac.uk/49782
[Accessed 21/10/2023]

Sheldon, S. (2016) The Decriminalisation of Abortion: An Argument for Modernisation *Oxford Journal of Legal Studies* [online] 36 (2) 334-365
Available from https://doi.org/10.1093/ojls/gqv026
[Accessed 21/10/2023]

Shin, J. M. (2015) Adam Smith's Impartial Spectator: His Reliance on Societal Values, Limits in Inspiring Altruism, and Application in Today's Context *Vanderbilt Undergraduate Research Journal* [online] 10 (2015) 1-10
Available from https://doi.org/10.15695/vurj.v10i0.4016
[Accessed 21/10/2023]

Shurpin, Y. (2019) *Judaism and Abortion* [online]
Available from https://www.chabad.org.uk/library/article_cdo/aid/529077/jewish/Judaism-and-Abortion.htm
[Accessed 22/09/2019]

Smart, J. and Williams, B. (1973) *Utilitarianism: For and Against*, UK: Cambridge University Press

Smith, J.A. (1996) Beyond the Divide Between Cognition and Discourse: Using Interpretative Phenomenological Analysis in Health Psychology *Psychology and Health* [online] 11 (2) 261-271
Available https://doi.org/10.1080/08870449608400256
[Accessed 21/20/2023]

Smith, J. and Dunworth, F. (2003) Qualitative Methodology. In: Valsiner, J. and Connolly, K. (Eds.) *Handbook of Developmental Psychology* p.603-621 UK: Sage Publications

Smith, J. A., Jarman, M. and Osborn, M. (1999) Doing Interpretative Phenomenological Analysis. [online] In M. Murray and K. Chamberlain (Eds.) *Qualitative Health Psychology: Theories and Methods* p.229-254 UK: Sage
Available from http://dx.doi.org/10.1002/9780470776278.ch10
[Accessed 21/10/2023]

Smith, J. A. (2007) Hermeneutics, Human Sciences and Health: Linking Theory and Practice *International Journal of Qualitative Studies on Health and Well-Being* [online] 2 (1) 3–11
Available from https://doi.org/10.1080/17482620601016120
[Accessed 21/20/2023]

Smith, J.A., Flowers, P. And Larkin, M. (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*, USA: Sage Publications, Thousand Oaks, CA

Smith, J.A. (2010) Interpretative Phenomenological Analysis: A reply to Amedeo Giorgi. Existential Analysis, 21(2) pgs. 186-192 [online]
Available from https://www.researchgate.net/publication/291942528
[Accessed 23/05/2024]

Smith, J.A. (2011) Evaluating the Contribution of Interpretative Phenomenological Analysis *Health Psychology Review* [online] 5 (1) 9-27
Available from https://doi.org/10.1080/17437199.2010.510659
[Accessed 21/10/2023]

Smith, J.A. and Osborn, M. (2015) Interpretative Phenomenological Analysis as a Useful Methodology for Research on the Lived Experience of Pain *British Journal of Pain* [online] 9 (1) 41–42
Available from https://doi.org/10.1177/2049463714541642

[Accessed 20/10/2023]

Smith, J. A. (2019) Participants and Researchers Searching for Meaning: Conceptual Developments for Interpretative Phenomenological Analysis *Qualitative Research in Psychology* [online] 16 (2) 166–81
Available from https://doi.org/10.1080/14780887.2018.1540648
[Accessed 22/10/2023]

Smith, J. (2021) *An Introduction to Interpretative Phenomenological Analysis* Workshop. Personal communique.

Smith, J.A., Flowers, P. and Larkin, M. (2022) *Interpretative Phenomenological Analysis: Theory, Method and Research*, 2nd ed. USA: Sage Publications

Smith, J. and Nizza, I. (2021) *Essentials of IPA* American Psychological Association, USA: Blackwell Publishing

Snape, D. and Spencer, L. (2003) The Foundations of Qualitative Research In J. Richie and J. Lewis (Eds.) *Qualitative Research Practice* [online] p. 1-23 USA: Los Angeles, Sage
Available from https://www.perlego.com/book/1431388/qualitative-research-practice-a-guide-for-social-science-students-and-researchers-pdf
[Accessed 21/10/2023]

Souza, M.T., Silva, M.D., Carvalho, R.d. (2010) Integrative Review: What Is It? How to Do It? Einstein (Sao Paulo). 2010 Mar; 8 (1) pgs.102-6. English, Portuguese. [online]
Available from https://doi:10.1590/S1679-45082010RW1134
[Accessed 16/05/2024]

Squires, V. (2023) Interpretative Phenomenological Analysis. In: Okoko, J.M., Tunison, S. and Walker, K.D. (eds) *Varieties of Qualitative Research Methods* [online] Springer Texts in Education. Springer, Cham
Available from https://doi.org/10.1007/978-3-031-04394-9_43
[Accessed 21/10/2023]

Staller, K.M. (2015) Qualitative Analysis: The Art of Building Bridging Relationships *Qualitative Social Work* [online] 14 (2) 145-153
Available from https://doi.org/10.1177/1473325015571210
[Accessed 21/10/2023]

Standke, C. (2008) Sharia - The Islamic Law *GRIN Verlag*, [online]
Available from https://www.grinlag/document/113665 cited in Almutairi (2007)
The Relationship Between Religion and Law in The Sphere of Abortion Regulation: A Case Study of Saudi Arabia and Ireland [online]
Available from https://www.academia.edu/35519610
Master's thesis, University of Maynooth, Ireland
[Accessed 16/06/2022]

Steel, D. (2008) David Steel: There is No Case for Changing the Abortion Act *The Independent* [online] 20/04/2008 at 00.00
Available from https://www.theindependent.co.uk/voices/commentators/david-steel-there-is-no-case-for-changing-the-abortion-act-818002.html
[Accessed 21/10/2023]

Steinmetz, G. (2005) Positivism and Its Epistemological Others. In: Steinmetz, G. *The Politics of Method in the Human Sciences* [online], p.1-56, USA: Duke University Press
Available (online) from https://doi.org/10.2307/j.ctv11smrtk or https://jstor.org/stable/j.ctv11smrtk
[Accessed 21/10/2023]

Stenfors, T., Kajamaa, A. and Bennett D. (2020) How to … Assess the Quality of Qualitative Research *Clinical Teacher* [online] 17 (6) 596-599
Available from https://doi.org/10.1111/tct.13242 Epub 13/08/2020
[Accessed 13/10/2023]

Stewart, K. (2023) 'If We Can Do It, You Can Do It': US Anti-Abortion Groups Ramp Up Activities in UK *The Guardian* [online] Epub. 02/04/2023 at 08:00
Available from https://www.guardian.com/world/2023/apr/02/us-anti-abortion-groups-uk-far-right
[Accessed 21/10/2023]

Stifani, B., Mishtal, J., Chavkin, W., Reeves, K., Grimes, L., Chakravarty, D., Duffy, D., Murphy, M. Horgan, T., Favier, M. and Lavelanet, A. (2022) Abortion Policy Implementation in Ireland: Successes and Challenges in the Establishment of Hospital-based Services *Qualitative Research in Health* [online] 17 (5) e0264494
Available from https://doi.org/10.1371/journal.pone.0264494
[Accessed 21/10/2023]

Studebaker, B. (2013) *The Critique of Virtue Ethics* [online multimedia]
Available https://www.benjaminstudebaker.com/2013/07/16/a-critique-of-virtue-ethics/
[Accessed 20/04/2022]

Strickland, S.L. (2012) Conscientious Objection in Medical Students: A Questionnaire Survey *Journal of Medical Ethics* [online] 38 (1) 22-5
Available from https://doi.org/10.1136/jme.2011.042770 Epub.18/07/2011
[Accessed 21/10/2023]

Suddick, K. M., Cross, V., Vuoskoski, P., Galvin, K. T., and Stew, G. (2020) The Work of Hermeneutic Phenomenology *International Journal of Qualitative Methods* [online] January-December 2020, 19 (2020) 1-14
Available from https://doi.org/10.1177/1609406920947600
[Accessed 21/10/2023]

Sulmasy, D. (2008) What is Conscience and Why is Respect For It So Important? *Theoretical Medical Bioethics* [online] 29 (3) 135-49
Available from https://doi.org/10.1007/s11017-008-9072-2
[Accessed 21/10/2023]

Sulmasy, D. (2019) Conscience, Tolerance, and Pluralism in Healthcare *Theoretical Medicine and Bioethics* [online] 40 (6) 507-521
Available from https://doi.org/10.1007/s11017-019-09509-5
[Accessed 21/10/2023]

Symons, X. (2017) Two Conceptions of Conscience and the Problem of Conscientious Objection *Journal Medical Ethics* [online] 43 (4) 245-247
Available from https://doi.org/10.1136/medethics-2016-103702
[Accessed 21/10/2023]

Symons, X. (2020) *Conscience and the Moral Permissibility of Institutional Conscientious Objection* Masters of Studies in Practical Ethics thesis, University of Oxford
Available from https://www.academia.edu/44211775
[Accessed 11/11/2023]

Table 1:
Three Perspectives [online image]
In: Tooley, M., Wolf-Devine, C., Devine, P. and Jaggar, A. (2009) *Abortion: Three Perspectives,* NY: Oxford University Press, p.ii
[Accessed 26/10/2023]

Table 2:
Kohlberg's (1958) Theory of Moral Development [online]
In: McCleod, S. (2013) Kohlberg's Stages of Moral Development [online multimedia]
Available from www.simplepsychology.org/kohlberg
[Accessed 04/04/2022]

Table 3:
Accounts of Personhood
In: Mackintosh, E.K. (2014) Abortion and Moral Context: Human Beings in a Moral Community [online], PhD thesis, Durham University p.26
Available from https://www.etheses.dur.ac.uk/11077/
[Accessed 25/10/2023]

Table 4:
Professional Responsibility Model of Obstetric Ethics [online image]
Chervenak, McCullough and Brent (2011) The Professional Responsibility Model of Obstetrical Ethics: Avoiding the Perils of Clashing Rights. *American Journal of Obstetrics and Gynaecology* [online], 205 (4) 315 - e1-5, p.315:e2
Available from https://doi.org/10.1016/j.ajog.2011.06.006
[Accessed 20/10/2023]

Table 5:
Four Markers for Evaluating Quality in IPA Research [online image]
Nizza, I., Farr, J. & Smith, J. (2021) Achieving Excellence in Interpretative Phenomenological Analysis (IPA): Four Markers of High-Quality. *Qualitative Research in Psychology* [online], 18 (3), 369-386 p.4
Available from https://doi.org/10.1080/14780887.2020.1854404
[Accessed 21/10/2023]

Table 6:
A Typology of Meaning [online image]
Smith, J. A. (2019) Participants and Researchers Searching for Meaning: Conceptual Developments for Interpretative Phenomenological Analysis *Qualitative Research in Psychology* [online], 16 (2) 166–81, p.168
Available from https://doi.org/10.1080/14780887.2018.1540648
[Accessed 22/10/2023]

Tardiff, R. (2015) Stewardship Challenges Abortion: A Proposed Means to Mitigate Abortion's Social Divisiveness *Linacre Quarterly* [online] 82 (3) 251–272
Available from https://doi.org/ https://doi.org/10.1179/2050854915y.0000000006
[Accessed 21/10/2023]

Teddlie, C. and Yu, F. (2007) Mixed Methods Sampling: A Typology with Examples *Journal of Mixed Methods Research* [online] 1 (1) 77-100
Available from https://doi.org/10.1177/1558689806292430
[Accessed 21/10/2023]

Thaddeus, S. and Maine, D. (1994) Too Far to Walk: Maternal Mortality in Context *Social Sciences and Medicine* [online] 38 (8) 1091-110
Available from https://doi.org/10.1016/0277-9536(94)90226-7
[Accessed 21/10/2023]

Theodosius, C. (2008) Emotional Labour in Health Care: The Unmanaged Heart of Nursing (1st ed.). Routledge. [online]
Available from https://doi.org/10.4324/9780203894958
Accessed 21/05/2024

Thomas, T. (2023) Outrage at Jail Sentence for Woman Who Took Abortion Pills Later Than UK Limit *The Guardian* [online] Epub. 12/06/2023

Available from https://www.guardian.com/ world/2023/jun/12/woman-in-uk-jailed-for-28-months-over-taking-abortion-pills-after-legal-time-limit
[Accessed 30/06/2023]

Tingle, J. (2017) Patient Consent and Conscientious Objection. *British Journal of Nursing*. 2017 Jan 26; 26 (2) pgs.118-119 [online]
Available from http://doi: 10.12968/bjon.2017.26.2.118. PMID: 28132564.
Accessed 20/05/2024

Tomkins, L., Brooks, J. and King, N. (2017) Using Interpretative Phenomenological Psychology in Organisational Research with Working Carers. In Brook, J. and King, N. (eds.) *Applied Qualitative Research in Psychology* (pp. 86-100). UK: Palgrave [online]
Available from http://dx.doi.org/10.1057/978-1-137-35913-1_5
[Accessed 26/10/2023]

Tooley, M., Wolf-Devine, C., Devine, P. and Jaggar, A. (2009) *Abortion: Three Perspectives,* USA: Oxford University Press

Toro-Flores, R., Bravo-Agüi, P., Catalán-Gómez, M.V. et al. (2017) Opinions of Nurses Regarding Conscientious Objection *Nursing Ethics* [online] 26 (4) 1027-1038
Available from https://doi.org/10.1177/0969733017731915
[Accessed 21/10/2023]

Toronto, C. E. and Remington, R. (Eds.) (2020) *A Step-by-Step Guide to Conducting an Integrative Review*. Springer.

Tuffour, I. (2017) A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach *Journal of Healthcare Communication* [online] 2 (4) 52
Available from https://doi.org/10.4172/2472-1654.100093
[Accessed 21/10/2023]

United Nations (1948) *Universal Declaration of Human Rights* UN Resolution 217A [online]
Available from https://www.un.org/en/about-us/universal-declaration-of-human-rights
[Accessed 01/11/2022]

United Nations (1995) *Platform for Action*, UN Fourth World Conference on Women (Beijing: UN, 1995) [online]
Available from https://www.un.org/en/conferences/women/beijing1995
[Accessed 01/22/2022]

Urmila, T. (2007) Ethical Issues in Clinical Research *Indian Journal of Plastic Surgery* 40 (10) 02-02
Available from https://www.researchgate.net/publication/338613916
[Accessed 30/10/2022]

Van Manen, M. (2007) Phenomenology of Practice *Phenomenology and Practice* [online] 1 (1) 11-30
Available from http://dx.doi.org/10.29173/pandpr19803
[Accessed 21/10/2023]

Varkey B. (2021) Principles of Clinical Ethics and Their Application to Practice. *Med Principles of Practice* [online] 30 (1) 17-28
Available from https://doi.10.1159/000509119
The final, published version of this article is available at https://www.karger.com/?doi.10.1159/000509119
[Accessed 21/10/2023]

Velasquez, M., Andre, C., Shanks, T. and Meyer, M. (2015) *Thinking Ethically* [online] Markkula Center for Applied Ethics 7 (1) 2-4
Available from https://www.academia.edu/1235634/Thinking_ethically
or https://www.scu.edu
[Accessed 12/11/2023]

Vendrall Ferran, I. (2015) Empathy, Emotional Sharing and Feelings in Stein's Work *Human Studies* [online] 38 (481-502) (2015)
Available from https://doi.org/10.1007/s10746-015-9346-4
[Accessed 21/10/2023]

Vermeulen, J., Fobelets, M., Fleming, V., Luyben, A., Stas, L. and Buyl, R. (2023) How Do Midwives View Their Professional Autonomy, Now and in Future? *Healthcare* [online] (2023) 11, 1800
Available from https://doi.org/10.3390/healthcare11121800

[Accessed 21/10/2023]

Vetlesen, A. J. (2001) Hannah Arendt on Conscience and Evil *Philosophy & Social Criticism* [online] 27 (5) 1–33
Available from https://doi.org/10.1177/019145370102700501
[Accessed 21/10/2023]

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedle, J., Phillips, E., Senu, H. and Holland, F. (2014) The Accordion and the Deep Bowl of Spaghetti: Eight Researchers' Experiences of Living IPA As a Methodology *The Qualitative Report* [online] 19 (24) 1-15 Available from https://doi.org/10.46743/2160-3715/2014.1216
[Accessed 21/10/2023]

Walsh-Gallagher, D. Sinclair, M. and McConkey, R. (2012) The Ambiguity of Disabled Women's Experiences of Pregnancy, Childbirth and Motherhood: A Phenomenological Understanding *Midwifery* [online] 28 (2) 156-62
Available from https://doi.org/10.1016/j.midw.2011.01.003 Epub. 13/05/2013
[Accessed 21/10/2023]

Watson, K. (2019) Abortion as a Moral Good *The Lancet* [online] 393 (10177) 1196-1197
Available from https://doi.org/10.1016/S0140-6736(19)30581-1
[Accessed 21/10/2023]

Weinstock, D. (2014) Conscientious Refusal and Health Professionals: Does Religion Make a Difference? *Bioethics* [online] 28 (1) 8-15
Available from https://doi.org/10.1111/bioe.12059 Epub. 30/09/2013
[Accessed 21/10/2023]

Wenar, L. (2021) John Rawls. In: Zalta, E.N. and Nodelman, U. (eds.) *The Stanford Encyclopaedia of Philosophy* [online] (Summer 2021 Edition),

Available from https://plato.stanford.edu/archives/sum2021/entries
[Accessed 21/10/2023]

Whittemore, R. and Knafl, K. (2005) The Integrative Review: Updated Methodology *Journal of Advanced Nursing.* 2005 Dec; 52 (5) pgs.546-53 [online]
Available from https://doi:10.1111/j.1365-2648.2005.03621.x.
[Accessed 15/05/2024]

Wicclair, M. (2011) *Conscientious Objection in Healthcare: An Ethical Analysis* USA: Cambridge University Press
Available from https://doi.org/10.1017/CBO9780511973727
[Accessed 30/09/2019]

Will, J. (2013a) Beyond Abortion: Why the Personhood Movement Implicates Reproductive Choice *American Journal of Law and Medicine* [online] 39 (4) 573-616
Available from https://doi.org/10.1017/S0098858800012077
[Accessed 21/10/2023]

Will, J. (2013b) Conscience Legislation, the Personhood Movement, and Access to Emergency Contraception 11/06/2013 *Faulkner Law Review* [online] 4 (2013) 411 Mississippi College School of Law Research Paper
Available from https://www.ssrn.com/abstract=2365427
[Accessed 21/10/2023]

Willig, C. (2013) *Introducing Qualitative Research in Psychology* 3rd ed. UK: OU Press

Willis, P. (2015) From the Things Themselves to a Feeling of Understanding: Finding Different Voices in Phenomenological Research *Indo-Pacific Journal of Phenomenology* [online] 4 (1) 1-13
Available from https://doi.org/10.1080/20797222.2004.11433888
or https://www.researchgate.net/publication/277888448
[Accessed 21/10/2023]

Wogaman, J. (2009) *Moral Dilemmas – An Introduction to Christian Ethics* UK: Westminster John Know Press

World Health Organisation (2004) *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets* Global Strategy adopted by the 57th World Health Assembly [online] Reference number WHO/RHR/04.8
Available from https://www.who.int/ publications/i/item/WHO-RHR-04.8

[Accessed 08/10/2019]

World Health Organisation (2012) *Safe Abortion Technical and Policy Guidance for Health Systems* [online] 2nd ed. Switzerland: WHO
Available from http://www.ncbi.nlm.nih.gov/books/NBK138196/
[Accessed 10/10/2019]

World Health Organisation (2021) *Preventing Unsafe Abortion* Evidence Brief Reference number WHO/RHR/19.21 [online]
Available from https://www/who.int/publications/i/item/WHO-RHR-19.21
[Accessed 21/10/2023]

WHO/UNFPA/ICM (2021) *State of the World's Midwifery* [online] Technical Document
Available from www.who.int/i/publications/sowmy_2021
[Accessed 21/10/2023]

World Health Organisation (2022) *Abortion Care Guideline* [online] Reference number 978 92 4 003948 3
Available from http://www.who.int/publications/i/item/9789240039483
[Accessed 12/06/2023]

World Health Organisation (2023) *Clinical Practice Handbook for Quality Abortion Care* [online] Reference number 978 92 4 007520 7
Available from www.who.int/publications/i/item/9789240075207
[Accessed 23/06/2023]

Yardley, L. (2008) Demonstrating Validity in Qualitative Psychology. Qualitative Psychology: A Practical Guide to Research Methods *Journal of Positive Psychology* [online] 12 (3) 295-296
Available from https://psycnet.apa.org/doi/10.1080/17439760.2016.1262624
[Accessed 21/10/2023]

Yee, S.F. (2019) The Framework of Transcendental Phenomenology. In: *A Phenomenological Inquiry into Science Teachers' Case Method Learning* [online] p.1-20 SpringerBriefs in Education. Singapore: Springer Education
Available from https://doi.org/10.1007/978-981-13-2679-0_1
[Accessed 21/10/2023]

Zaami, S., Rinaldi, R. and Montanari-Vergallo G. (2021) The Highly Complex Issue of Conscientious Objection to Abortion: Can the Recent European Court of Human Rights ruling Grimmark v. Sweden Redefine the Notions of Care Before Freedom of Conscience? *European Journal of Contraception, Reproductive Health Care* [online] Epub 06/04/2021; 26 (4) 349-355
Available from https://doi.org/10.1080/13625187.2021.1900564
[Accessed 21/10/2023]

Zamawe, F.C. (2015) The Implication of Using NVivo Software in Qualitative Data Analysis: Evidence-Based Reflections *Malawi Medical Journal* [online] 27 (1) 13-5
Available from https://doi.org/10.4314/mmj.v27i1.4
[Accessed 21/10/2023]

Zimmermann, J. (2015) What is Hermeneutics? In: Zimmermann, J. *Hermeneutics: A Very Short Introduction*, Very Short Introductions (Oxford, 2015; online edn, *Oxford Academic* 22 Oct. 2015)
Available from https://doi.org/10.1093/actrade/9780199685356.003.0001
[Accessed 21/10/2023]

Appendices

Appendix 1: UREC Minimal Risk Registration – Ethics Approval 21/NAH/013

Appendix 2: Recruitment Flyer

Appendix 3: Participant Information Sheet

Appendix 4: Participant Consent Form

Appendix 5: Interview Schedule

Appendix 6: Search Strategy

Appendix 7: Critical Appraisal Skills Programme Systematic Review

Appendix 8: Reasons Why Women Have Abortions (Chae et al. 2021)

Appendix 9: Broad Reasons Used to Argue For/Against CO (Fleming et al. 2018)

Appendix 10: Spectrum of CO Views

Appendix 11: A Case Study: Ana Maria Acevado

Appendix 12: Case Level Pen Portrait 'Thumbnail' Summaries'

Appendix 13: Transcription

Appendix 14: Abbreviations

Appendix 15: Glossary

Appendix 16: Conferences/Presentations

Appendix 17: Publications

Appendix 1: UREC Minimal Risk Registration; Ethics Approval 21/NAH/013

Dear Jacqueline

Thank you for registering your study as minimal risk.

PI: Jacqueline Richards

Title of study: THE LIVED EXPERIENCE OF THE ETHICAL DILEMMAS OF MIDWIVES IN CONSCIENTIOUS OBJECTION (CO) TO ABORTION USING INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA) (Grahame Smith)

Minimal Risk UREC approval reference number: 21/NAH/013

Approval is given on the understanding that:

- The study is conducted in accordance with the Minimal Ethical Risk Guiding Principles
- Any adverse reactions/events which take place during the course of the project are reported to the Committee immediately by emailing researchethics@ljmu.ac.uk;
- Any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately emailing researchethics@ljmu.ac.uk;
- The LJMU logo is used for all documentation relating to participant recruitment and participation e.g. poster, information sheets, consent forms, questionnaires. The study consent forms, data, information etc. will be accessible on request to a student's supervisory team and/or to responsible members of Liverpool John Moores University for monitoring, auditing and data authenticity purposes.
- Where any substantive amendments are proposed to the protocol or study procedures that change the associated risk from minimal to low risk (use the decision tool to establish the associated risk), the investigators must complete an ethics application form describing all aspects of the study and submit for ethical review and approval as required.

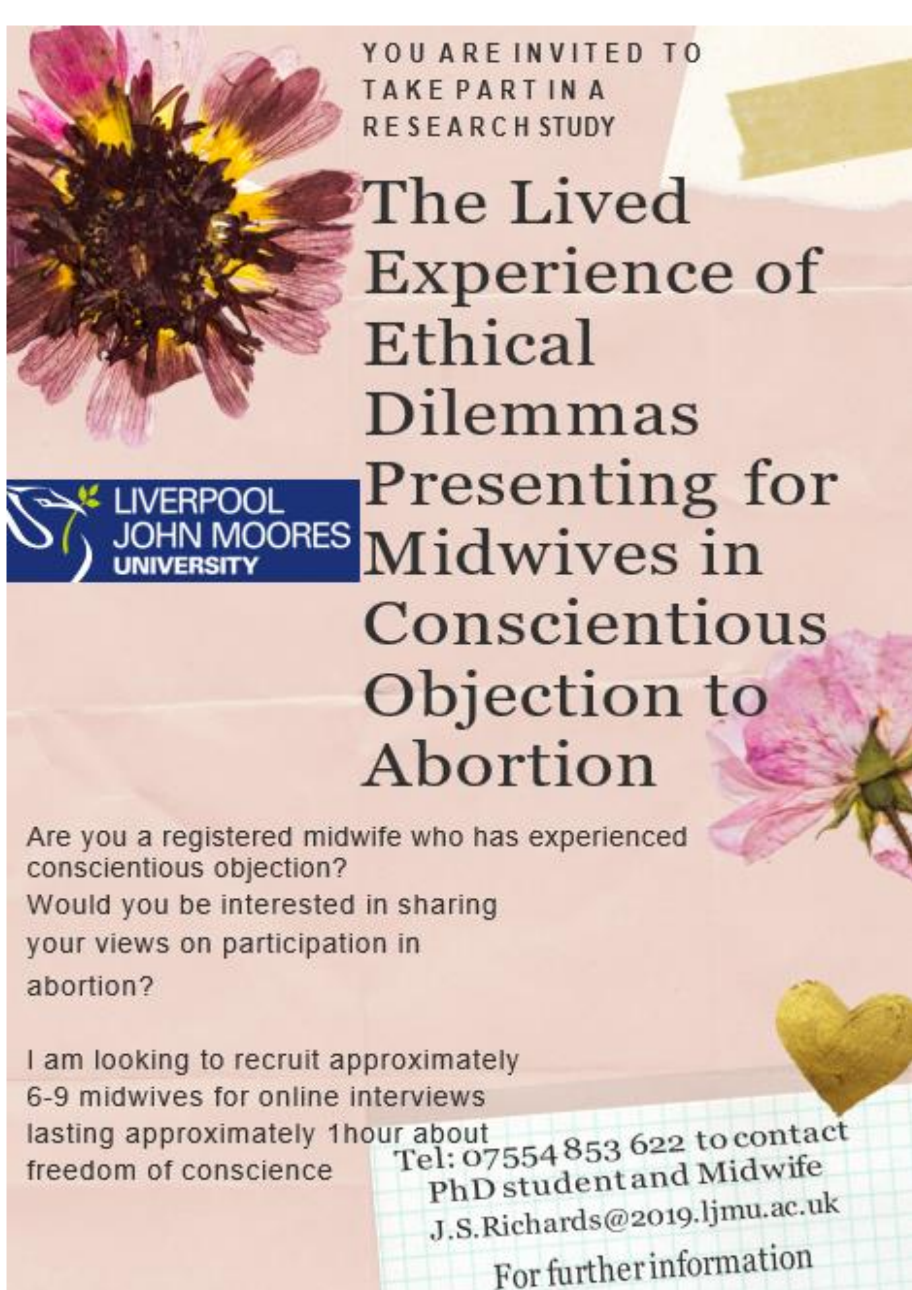
- Where relevant appropriate gatekeeper / management permission must be obtained prior to the study commencing at the study site concerned.

Please note that approval is given for a period of five years from 13/07/2020 and therefore the expiry date for this project will be 5 years from the approval date. An application for extension of approval must be submitted if the project continues after this date.

Best wishes

UREC

Appendix 2: Recruitment Flyer



Appendix 3: Participant Information Sheet

Participant Information Sheet

LIVERPOOL JOHN MOORES UNIVERSITY

LJMU's Research Ethics Committee Approval Reference: Richards 21/NAH.013

Project Title: The Lived Experience of Ethical Dilemmas Presenting for Midwives in Conscientious Objection to Abortion Using Interpretative Phenomenological Analysis

School/Faculty: Nursing and Allied Health

Principal Investigator: Jacqueline Richards J.S.Richards@2019.ljmu.ac.uk , +44 7554 853622.

Supervisors: Dr Grahame Smith 0151 231 4115, G.M.Smith@ljmu.ac.uk.

Dr Julie Connolly, 0151 231 4397, J.Connolly@ljmu.ac.uk

You are being invited to take part in a study. Before you decide it is important for you to understand why the study has been commissioned and what participation will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take your time to decide whether you wish to take part or not. Thank you for reading this.

1. What is the purpose of the study?

The fourth clause of the UK 1967 Abortion Act allows health care practitioners (HCP) to object to providing abortion services on the grounds of conscience. Since its introduction, however, burgeoning numbers, an alteration from surgical to medical techniques and a change in the context in midwives' practice have led some commentators to question the adequacy of provision for individual objection, known as "accommodation". This study proposes to capture the lived experience of midwives' dilemmas presenting in conscientious objection to abortion in the UK. You can help to contribute to greater understanding of the midwife's role in respect of participation in procedures with which practitioners may not be entirely comfortable and the

effectiveness of policy designed to support decision-making. This will establish ways of overcoming conflict when employees' contractual obligations call for them to partake in duties related to the abortion process that may contravene their personal beliefs. This research will address individual as well as professional opinions on this matter.

2. Why have I been invited to participate?

You have been invited to participate because you are a registered midwife who has an expressed interest in the research, aimed at understanding midwives' experiences of dealing with abortion cases in the UK or you may have an opinion to express on the matter of conscientious objection. I will be recruiting approximately 10-15 midwives to interview online.

3. Do I have to take part?

No. It is up to you to decide whether to take part or not. If you do decide to participate you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw at any time by informing the investigators without giving a reason. You can withdraw your data any time before data analysis takes place.

4. What will happen to me if I take part?

Once you have completed a participant consent form, you will be invited to arrange a mutually convenient date and time for discussion with a researcher, usually within 3 days. Interviews will take place online. I will use an interview guide to conduct the interview, which will last approximately 60 minutes. The interview will be audio-recorded then transcribed at a later date. All identifying data will be removed at this stage. If selected, you may be invited back to take part in a follow up interview online in order to clarify further information online at your convenience, lasting up to 60 minutes. You will be provided by a copy of the final transcript of your interview. You are not obliged to take part in any further interviews by agreeing to take part in this study. The researcher will analyse all of the interviews and provide a synthesised report of findings. Findings will be submitted to Liverpool John Moores' University in the form of a PhD thesis which will be made available on this website.

5. Will I be recorded and how will the recorded media be used?

You will be audio recorded. The audio recordings of your interviews made during this study will be used only for analysis. No other use will be made of them without your

written permission, and no one outside of the project will be allowed access to the original recordings. Interviews will be audio recorded on a password protected audio recording device. The recording will be transferred to secure storage and deleted from the recording device as soon as possible. They will be deleted from secure storage 5 years after the research has been submitted for publication.

6. What are the possible disadvantages and risks of taking part?

Interviews may bring about emotional distress due to the sensitive nature of the research topic. You do not have to answer questions you do not feel comfortable answering, and you are able to withdraw before and during the interview at any time.

If you are personally affected by participation in this study, you may wish to seek support/advice from:

ARCH (Abortion Recovery Care & Helpline) which is dedicated to promoting the emotional, psychological and spiritual well-being of clients, by the provision of real understanding, counselling and supportive help to women, men and families after an abortion.

All of ARCH services are offered **confidentially, compassionately, without judgement and free of charge** for those struggling in the aftermath of an abortion through:

The ARCH **Helpline**, staffed by volunteer Befrienders.

If you want to talk to someone who will listen compassionately call **03456038501** (calls are free from most landlines and contract phones) 7pm-10pm every evening, or 9am-5pm Mon-Fri.

Free, one-to-one **Counselling**

Face-to-Face or Telephone or Secure Video.

For more information call ARCH's Helpline - **03456038501**. You can also email ARCH - **clare@archtrust.org.uk** - or use the contact form on their website – or contact Clare Bremner directly on 07984-040947

7. What are the possible benefits of taking part?

The research reports can contribute towards future strategies, guides and publications related to policy and legal debate concerning conscientious objection. Your employment rights will not be affected by your participation.

8. What will happen to the data provided and how will my taking part in this project be kept confidential?

The information you provide as part of the study forms the research study data. Any research study data from which you can be identified is known as personal data. Personal data will only be accessed by the research team, all healthcare professionals. We will use unique identifiers in transcripts and reports to help protect the identity of individuals. Anonymised data (interview transcripts) may be used for additional or subsequent research studies and will be stored in an academic online database with written permission. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

9. Limits to confidentiality

Attempts will be made to guarantee confidentiality and strict adherence to GDPR principles of data protection are assured. Unique pseudonyms will be used and identifiers will be removed, once the audio recording has been transcribed. Details of case studies cited with personal data will not be used during the interview or at any point subsequently. The investigator will work with the participant to minimise and manage the potential for indirect identification of participants.

10. What will happen to the results of the research project?

The findings will be analysed, synthesised and used in partial requirement of Jacqueline Richards' PhD thesis (Faculty of Health, Liverpool John Moores' University). Additionally, articles about the study will be published in academic and professional journals. Anonymised aspects of the study may be used for teaching purposes.

11. Who is organising and funding/commissioning the study?

This study is organised and funded by Liverpool John Moores' University.

12. Who has reviewed this study?

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores' University Research Ethics Committee Reference number:

13. What if something goes wrong?

If you have a concern about any aspect of this study, please contact Jacqueline Richards who will do their best to answer your query. The researcher should acknowledge your concern within 10 working days and give you an indication of how the matter will be taken forward. If you wish to make a complaint, please contact the chair of the Liverpool John Moores' University Research Ethics Committee (researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

14. Data Protection Notice

Liverpool John Moores' University (LJMU), UK, is the sponsor for this study. We will be using information from you in order to undertake this study and will act as the data controller for this study This means that we are responsible for looking after your information and using it properly. LJMU will keep identifiable information about you until the researcher has submitted her PhD. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study after data analysis has begun, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information. You can find out more about how we use your information by contacting secretariat@ljmu.ac.uk.

If you are concerned about how your personal data are being processed, please contact LJMU in the first instance at secretariat@ljmu.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research.

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO). Our Data Protection Officer can be contacted on secretariat@ljmu.ac.uk

15. Contact for further information

Principal Investigator: Jacqueline Richards J.S.Richards@2019.ljmu.ac.uk , +44 7554 853622.

Supervisors: Dr Grahame Smith 0151 231 4115, G.M.Smith@ljmu.ac.uk.

Dr Julie Connolly, 0151 231 4397, J.Connolly@ljmu.ac.uk

Thank you for reading this information sheet and for considering taking part in this study.

Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form.

Appendix 4: Consent Form

Participant Consent Form

Project Title: The Lived Experience of Ethical Dilemmas Presenting for Midwives in Conscientious Objection to Abortion Using Interpretative Phenomenological Analysis

School/Faculty: Nursing and Allied Health

Principal Investigator: Jacqueline Richards J.S.Richards@2019.ljmu.ac.uk , +44 7554 853622.

Supervisors: Dr Grahame Smith 0151 231 4115, G.M.Smith@ljmu.ac.uk.

Dr Julie Connolly, 0151 231 4397, J.Connolly@ljmu.ac.uk

Please initial each box.

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my participation is voluntary and that I am free to withdraw at any time until data analysis has been carried out, without giving a reason and that this will not affect my legal rights.

3. I understand that any personal information collected during the study will remain confidential. I understand that I can remove my data before analysis takes place.

4. I agree to take part in the above study

5. I understand that the interview/ will be audio recorded and I am happy to proceed

6. ☐ I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised.

Name of Participant Date Signature

Name of Researcher Date Signature

Name of Person taking consent Date Signature

(if different from researcher)

Note: When completed 1 copy for participant and 1 copy for researcher

----

Appendix 5: Interview Schedule

What do you understand by the term ‘conscientious objection’ in midwifery?

What do you think are the main reasons for healthcare professionals conscientiously objecting?

Have you ever experienced conscientious objection in your professional role in the workplace?

What are your views on conscientious objection?

What do you understand by the term ‘participation’ in abortion?

What do you think are the ethical dilemmas faced by midwives when caring for women undergoing abortion?

Do you think policy or procedures help midwives’ decision-making?

Do you think the current law protects midwives?

How do you think the context in which midwives practise is different to 1967 when the law was introduced?

Can you tell me a bit more about what you think is the impact of conscientious objection a) on the service-user? b) on the midwife? C) on society in general?

Do you think the situation could be improved anyway? If so, how?

Appendix 6: Search Strategy

Type of Literature	Source of information	Type of source	Search terms	Results yielded
Academic literature of online sources	PubMed/Medline	Database; US National Library of Medicine	"Conscientious objection" + "abortion" + MESH terms: "termination of pregnancy; "ethics/law"; "midwives"; + "*midwi*" "freedom of choice"; "women's reproductive health"; "research"	= 2612 700 453 763 542 (with truncated stem term =354) 436 307 1507
Academic literature of online sources	Elsevier evolve	Analytical database includes Scopus	"Conscientious objection" + "abortion" + MESH terms: "termination of pregnancy; "ethics/law"; "midwives"; + "*midwi*" "freedom of choice"; "women's reproductive health"; "research"	2300 2394 2391 2419/2407 2441 2391 2852 2449
Academic literature of online sources	Wiley	Online library	"Conscientious objection" + "abortion" + MESH terms: "termination of pregnancy; "ethics/law"; "midwives"; + "*midwi*"	460 283,230 311,382 292,616/341,225 281,127 288,690

			“freedom of choice”; “women’s reproductive health”; “research”	301,156 488.806 786,522
Academic literature of online sources	Science direct	Database	“Conscientious objection” + “abortion” + MESH terms: “termination of pregnancy; “ethics/law”; “midwives”; + “*midwi”* “freedom of choice”; “women’s reproductive health”; “research”	3608 636 299 893/2223 270 1 624 428 2204
Academic literature of online sources	Taylor and Francis Online	International academic publisher	“Conscientious objection” + “abortion” + MESH terms: “termination of pregnancy; “ethics/law”; “midwives”; + “*midwi”* “freedom of choice”; “women’s reproductive health”; “research”	79,843 7,012 2613 28,330/49,909 1,185 1 36,005 32,819 69,005
Academic literature of online sources	Cochrane Collection Plus - EBSCO, CINAHL, Biomedical Reference Collection, EMBASE, BIOSIS	Database	“Conscientious objection” + “abortion” + MESH terms: “termination of pregnancy; “ethics/law”; “midwives”; + “*midwi”*	1,786 587 157 738/563 55 0

			“freedom of choice”; “women’s reproductive health”; “research”	6 20 273
Academic literature of online sources	Nice evidence search	National Institute of Clinical Excellence	“Conscientious objection” + “abortion”	1 (NG140)
Academic literature of online sources	Global Health Library	CABI produced database, focusing on public health centring on low income countries	“Conscientious objection” + “abortion” + MESH terms: “termination of pregnancy; “ethics/law”; “midwives”; + “*midwi”* “freedom of choice”; “women’s reproductive health”; “research”	169 61 10 33/64 4 4 2 25 60
Academic literature of online sources	Tripdatabase.com	Database of clinical research	“Conscientious objection” + “abortion” + MESH terms: “termination of pregnancy; “ethics/law”; “midwives”; + “*midwi”* “freedom of choice”; “women’s reproductive health”; “research”	522 72 36 357/374 19 19 10 60 412
Academic literature of online sources	International Pharmaceutical Abstracts	Database produced by Web of Science Group, part of	“Conscientious objection”+ “abortion” + MESH terms: “termination of pregnancy;	431 167 100

		EBSCOhost, CINAHL, Scopus	"ethics/law"; "midwives"; + "*midwi*" "freedom of choice"; "women's reproductive health"; "research"	147/98 22 0 7 56
Academic literature of online sources	Nursing Reference Centre Plus	Database premier source of evidence designed especially for nurses	"Conscientious objection" + "abortion" + MESH terms: "termination of pregnancy; "ethics/law"; "midwives"; + "*midwi*" "freedom of choice"; "women's reproductive health"; "research"	1,786 587 157 738/563 55 0 6 20 273
Academic literature of online sources	Google scholar	Inter-disciplinary web search for direct links to full text journal subscriptions	"Conscientious objection" + "abortion" + MESH terms: "termination of pregnancy; "ethics/law"; "midwives"; + "*midwi*" "freedom of choice"; "women's reproductive health"; "research"	188,000 30,900 17,100 83,800/160,000 13,100 17,400 102,000 25,600 237,000
Manual academic literature search by citation/reference	All works and citations by Professor V. Fleming and M.Wicclair	Online multi-media	"Fleming" / "Wicclair" + "Conscientious objection"	11,800 1,060

			and “conscientious objection to abortion”	
Textbooks	“Conscientious Objection in Healthcare” (Wicclair 2011) + “Conflicts of Conscience in Healthcare” (Lynch 2008) + “The Value of Life” (Harris 1985) + “The Body” (Fox 2012) + IPA (Smith, Flowers and Larkin 2022)	Hard paper copy	By author and/or “Conscientious objection” and “conscientious objection to abortion”	6
Grey Literature	WHO/PAHO, United National for Family Planning Association (UNFPA), Department of Health (DoH) National Health Service (NHS), UK Health Security Agency (formerly Public Health England (PHE), National institute for Health and Care Excellence (NICE), Office for National Statistics (ONS), Nursing and Midwifery Council	Reports and guidance	By organisation and/or “conscientious objection” + “abortion”	WHO – 12 UNFPA - 9 DoH – 4,484 PHE – 4589 NICE – 1 ONS – 4 + 14 NMC – 23 + 4 British Library – 217 + 8 Etheses – 7 Pro-Quest – 150,888 + 24,607

	(NMC), Ethos, Pro Quest (Theses’)			
Trade sources	Royal College of Midwives (RCM), Royal College of Nursing (RCN), British Medical Association, American Medical Association (AMA)	Reports and guidance	By organisation and/or “Conscientious objection (in medicine)” and “conscientious objection to abortion” and by specific occupational groups (midwives, nurses, medical, healthcare professionals/workers)	Please refer to Endnote – ongoing
General media	YouTube, UK - The Times, The Sunday Times, The Independent, The Daily Telegraph, The Daily Express, The Daily Mail and The Guardian; in the US – The Washington Post, The Chicago Tribune etc).	Reputable published newspapers, social media	“Conscientious objection (in medicine)” and “conscientious objection to abortion”	Ongoing

Appendix 7: Critical Appraisal Skills Programme Review

Paper for appraisal and reference: Chae S, Desai S, Crowell M, Sedgh G. Reasons why women have induced abortions: a synthesis of findings from 14 countries. Contraception. 2017 Oct; 96 (4) 233-241 Available from https://doi.org//10.1016/j.contraception.2017.06.014 Epub 2017 Jul 8.

Section A: Are the results of the review valid?

1. Did the review address a clearly focused question?

Yes	x
Can't Tell	
No	

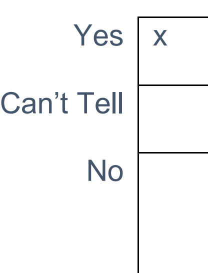
HINT: An issue can be 'focused' In terms of
- the population studied
- the intervention given
- the outcome considered

Comments: Aims to provide a good umbrella view, very comprehensive but broad aims – 14 countries (where accessible facilities may differ, though comparisons made on basis of information on geographic region, income classification, abortion law restrictiveness, total fertility rate, and modern contraceptive prevalence (Table 1).) There were no details of reasons for choice of countries i.e. inclusion/exclusion criteria. The non-homogenous research population makes parallels inconclusive e.g. "Data from three countries where multiple reasons could be reported in the survey showed that women often have more than one reason for having an abortion." Very realistically multi-causal justifications can happen but the conclusion (which are only vague anyway) cannot be drawn from merely quantitative

statistical analysis. However, the paper does try to substantiate clinical justifications related to abortion decision-making which is relevant to the thesis because of the possibility of midwives making case-by-case distinctions based on these options. Analysing statistical evidence seems an appropriate intervention (if like the U.K. the permissibility of legal abortion is criterion-based), but authors recognise some limitations in the data citing the reasons for abortion – "where available". Methods - interviewer-administered and conducted in-person. Outcomes considered in terms of areas for future research.

2. Did the authors look for the right type of papers?

Yes
Can't Tell
No



HINT: 'The best sort of studies' would

- address the review's question
- have an appropriate study design (usually RCTs for papers evaluating interventions)

Comments:

Built on earlier reviews (from 20 yrs previous, so a well-overdue update needed) and the paper aimed to fill gaps in knowledge. Theoretically grounded on 2 peer-reviewed articles (minimal number). Some consistency between 11 countries by analysing standardized surveys designed to collect comparable data across countries, seems appropriate but only to a certain extent. Heavily reliant on truth-telling and accurate interpretation of data. Given taboos of the subject matter, often health seeking behaviour/abortion-decision-making are assumed to be cloaked in secrecy and misrepresentation. The paper recognises under-

representation/hidden nature of the phenomenon e.g. "Women who report their abortion might have different reasons for seeking one, compared to those who do not report them."

Is it worth continuing?

3. Do you think all the important, relevant studies were included?

Yes	X
Can't Tell	
No	

HINT: Look for
- which bibliographic databases were used
- follow up from reference lists
- personal contact with experts
- unpublished as well as published studies
- non-English language studies

Comments: Veers towards looking at who has abortions sometimes, rather than why – undue emphasis on socio-demographics.

4. Did the review's authors do enough to assess

Yes	x

HINT: The authors need to consider the rigour of the studies they have

quality of the included studies?	Can't Tell		identified. Lack of rigour may affect the studies' results ("All that glisters is not gold" Merchant of Venice – Act II Scene 7)
	No		

Comments: yes, 22 quality references

5. If the results of the review have been combined, was it reasonable to do so?	Yes	x	HINT: Consider whether • results were similar from study to study • results of all the included studies are clearly displayed • results of different studies are similar • reasons for any variations in results are discussed
	Can't Tell		
	No		

Comments: One limitation of using descriptive statistical analysis provided e.g. "our findings may reflect the structured response categories listed in the questionnaires and our classification of these categories." Timeframe of 5 yrs also mentioned (prior to the survey. Marital status, educational attainment, and residence may have changed in that time).

Section B: What are the results?

"Socioeconomic concerns or limiting childbearing were the most frequently cited reasons in most of the countries in our study."

6. What are the overall results of the review?

HINT: Consider

- If you are clear about the review's 'bottom line' results
- what these are (numerically if appropriate)
- how were the results expressed (NNT, odds ratio etc.)

Comments: The article did what it set out to do – providing tools for policy-makers - whilst recognising the limitations in doing so. To this end results can be described as numerically appropriate and suitably explained.

7. How precise are the results?

HINT: Look at the confidence intervals, if given

Comments:

Section C: Will the results help locally?

Question		Answer	Hint
8. Can the results be applied to the local population?	Yes	x	HINT: Consider whether • the patients covered by the review could be sufficiently different to your population to cause concern • your local setting is likely to differ much from that of the review
	Can't Tell		
	No		

Comments: for researchers as well as policy-makers and those responsible for programme design.

Question		Answer	Hint
9. Were all important outcomes considered?	Yes	x	HINT: Consider whether • there is other information you would like to have seen
	Can't Tell		
	No		

Comments: why certain countries were chosen above others – on what basis was this judged? Armenia to America seems an eclectic mix.

10. Are the benefits worth the harms and costs?

Yes	x
Can't Tell	
No	

HINT: Consider

- even if this is not addressed by the review, what do **you** think?

Comments: few harms and costs – data relevant, valid and useful.

Appendix 8: Reasons Why Women Have Abortions (Chae et al. 2021)

Survey-specific reasons for having an abortion that comprise each reported Main Reason category by country and year of survey

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
Armenia, 2010	Spacing next pregnancy	Did not want (any more) children	Socioeconomic reasons	Partner did not want the child	–	Health of mother	Risk of birth defects	Sex selection (wanted a boy), sex selection (wanted a girl), other
Azerbaijan, 2006	Spacing next pregnancy	Did not want (any more) children	Socioeconomic reasons	Partner did not want the child	–	Health of mother	Risk of birth defects	Child's sex selection, other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
Belgium, 2011	No desire for a child at the moment	Woman is too old, family complete	Student, financial problems, professional situation, housing problems	Recently broke up, partner did not want the child, casual relationship, new relationship, not married, couple problems, family/friends have problems with the	Woman is too young	Health problems of mother, mental health problems	Health problems of unborn child	Rape, incest, political refugee, other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
				relationship, divorce				
Congo Republic, 2012	Too short birth interval	Too old to have a child, has many children	Lack of money, to keep with schooling, to keep working	Husband/partner does not like to have any more children	Too young to have a child, fear of parents	Health problems	–	Other
Gabon, 2012	Too short birth interval	Too old to have a child, has many children	Lack of money, to keep with schooling, to keep working	Husband/partner does not want to have any more children	Too young to have a child, fear of parents	Health problems	–	Other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
Georgia, 2010	Want to postpone childbearing	Want no (more) children	Socioeconomic reasons	Partner objected to pregnancy	–	Pregnancy was life or health threatening	Risk of birth defects	Other
Ghana, 2007	Wanted to delay childbearing, wanted to space childbearing	–	No money to take care of baby, wanted to continue schooling, wanted to	Did not love the father, did not want to stay w/the father, partner did not want child/denied	Too young to have child, not ready to be a mother, to avoid	Health of mother	Risk of birth defect	Because of rape, no one to help me look after the child, other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
			continue working	paternity, father of child died	shame, afraid of parents, parents insisted			
Jamaica, 2002	–	Respondent did not want (any) children	Could not afford to have another child	Partner did not want (any) children, did not have a partner	–	Pregnancy was life threatening	Risk of birth defects	Don’t know, other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
Kyrgyz Republic, 2012	Spacing next pregnancy	Respondent did not want (any more) children	Socioeconomic reasons	Partner did not want child, not married	–	Health of mother	Risk of birth defect	Sex selection/wanted boy, sex selection/wanted girl, other
Nepal, 2011	Wanted to delay childbearing, wanted to space child	Did not want (any more) children	No money to take care of baby, wanted to continue schooling, wanted to	Did not love the father, partner did not want child, father of child died	Too young to have a child, not ready to be a mother	Health of mother	Risk of birth defect	Child's sex, b/c of rape, to avoid shame, no one to look after child, other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
			continue working					
Russia, 2011	Birth spacing	She did not want another child	Could not afford another child	Partner opposed to another child	–	Health reasons	–	Other
Turkey, 2003	Just delivered/had little child	Like to limit, has enough children, woman too old	Economic problems (lack of money, unemployment), economic and other problems,	Husband was in the army/was abroad, husband does not want it, problems within	–	Health problem - woman, health problem -	Health problem - fetus, usage of medicine during	Does not want the child/too early for a child, problems w/pregnancy (probability of

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
			she is working/nobody to look after the child	the family/planning to divorce, husband too old/disabled, not married		woman and fetus	pregnancy	spontaneous abortion), unwanted pregnancy, unintended pregnancy, IUD failure, not able to take care of children (unspecified), other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
United States, 2004	Not ready for a(nother) child, timing is wrong	Have completed my childbearing, have other people/children depending on me, children are grown	Can't afford a baby now; unemployed; can't afford basic needs of life; can't leave job to take care of baby; would have to find a new place to live; not enough financial	Don't want to be single mother, am having relationship problems, husband or partner wants me to have an abortion, partner abusive	Don't feel mature enough to raise a(nother) child, feel too young, parents want me to have an abortion	Physical problem w/my health	Possible problems affecting the health of the fetus	Was a victim of rape, don't want people to know I had sex or got pregnant, other

Country and year of survey	Main reason category							
	Wants to postpone/space childbearing	**Wants no (more) children**	**Socioeconomic concerns**	**Partner-related reasons**	**Too young; parent(s) or other(s) object to pregnancy**	**Risk to maternal health**	**Risk to fetal health**	**Other**
			support from partner; partner unemployed; on welfare; would interfere w/education or career plans; I'm a student or planning to study					

Appendix 9: Overview of Broad Reasons Used to Argue For or Against CO (Fleming et al. 2018)

Broad reasons used to argue for or against CO		Example of reason mentions
++: Broad reason containing only narrow reasons arguing for CO	CO protects HCP (+ 5/− 0; rm.:9)[MR]	“We live in a society that has become increasingly individual over time, with citizens encouraged to seek what is best for themselves. In one sense, a right of conscience is a counter, focusing as it does on perceived obligation, not self-satisfaction. But the right is strongly individualistic, crediting the individual’s conviction against the general perception of what is socially desirable. One might think that creating a legal right, especially a broad one not limited to religious conviction, will contribute to an unhealthy sense that each individual judges for herself, giving little or no weight to a sense of community and to prevailing opinions within the society about what is needed.”[15]
	Ignoring conscience of HCP is a form of discrimination (+ 3/− 0; rm.:3) [MR]	“Their feeling that they have yielded to compulsion and violated their most deeply held beliefs and principles may involve profound resentment and loss of self-respect.” [18]
	Freedom of conscience (+ 2/− 0; rm.:7) [MR]	“They assert that, because provision of care can be conscience based, full respect for conscience requires accommodation of both objection to participation and commitment to performance of services such that the latter group of providers also have the right to not suffer discrimination on the basis of their convictions.” [19]

Broad reasons used to argue for or against CO		Example of reason mentions
	Practice of disclosure creates risk for the HCP (+ 5/− 0; rm.:13) [PR]	“Ironically, in most jurisdictions, the same facility-religious or not-may alternate between refusing and willing. For example, a clinic that only refuses to provide nontherapeutic abortions typically will have to accommodate a doctor who will not participate in therapeutic abortions, sterilizations, or contraceptive care.” [21]
	Religious convictions form conscience (+ 3/− 0; rm.:7) [RR]	“Religious beliefs, which statutes and philosophical traditions recognize as a basis for acts of conscience, may be of as fundamental significance to a willing provider as they are to a refuser.” [21]
	Controversies in religion-based argumentation (+ 2/− 0; rm.:2) [RR]	“To highlight exclusively religiously based conscientious objection to the neglect of professional conscientious objection renders conscientious objection a strange and alien phenomenon to the nonreligious. More importantly, to do so erroneously suggests that the professional has no positions concerning the ethics of her own practice.” [20]
+: Broad reason containing predominantly narrow reasons for CO	Respecting importance of conscience or CO (+ 11/− 1; rm.:24) [MR]	“When we describe a person as having acted on the grounds of conscience, we typically mean that she “acted on the basis of a sincere conviction about what is morally required or forbidden.”15 Thus, claims of conscience can be understood as a subset of moral claims generally one that connotes a strong link with individual identity and a preference for suffering significant burdens rather than acting against conscientious belief.” [18]
	Criteria for CO (+ 9/− 2; rm.:36) [MR]	“It must be consistent with the HCP’s other beliefs and actions, particularly those in proximate areas of concern.” [24]

Broad reasons used to argue for or against CO		Example of reason mentions
	Moral integrity needs to be respected (+ 5/− 1; rm.:22) [MR]	"A moral system that tolerated intolerance would seem internally inconsistent'." [24]
	Normative value of CO (+ 4/− 1; rm.:13) [MR]	"Conscience, however, is not so one-sided. Nor is medical decision-making so straightforward. First, medical decisions -especially those involving questions of life and death - inspire divergent moral convictions. Second, as I will explain, medical decisions do not simply implicate conscience for the provider. They should be thought of instead as involving, at minimum, three parties: patients, providers, and institutions. This three-sided relationship complicates moral decision-making, with each party asserting potentially conflicting claims." [22]
	Conscience is closely related to identity and sense of self (+ 4/− 1; rm.:8) [MR]	"Acting according to conscience has real importance less because it is about being (morally or politically) right than because it is central to being a whole person. Both theory and experience indicate that conscience is closely related to one's moral integrity or sense of self." [21]
	Respect for autonomy (+ 3/− 1; rm.:10) [MR]	"Professional conscientious objection in medicine is an instance of the autonomy of the professions from what is simply legal.' Professional conscientious objection differs from religiously grounded objection by being reason-based." [20]
	Religion does not permit involvement (+ 6/− 1; rm.:16) [RR]	"A different basis for possible differentiation concerns what is at stake. Perhaps religious objectors usually perceive that more is at stake, including their eternal welfare. This sense of magnitude of impairment might be related to what a claimant would be willing to sacrifice to avoid doing a wrongful act." [15]

Broad reasons used to argue for or against CO		Example of reason mentions
	Safeguarding conscience (+ 6/− 1; rm.:23) [LR]	"As a two-way street, the conscience clause acknowledges the legitimacy of conscience at the level of institutions, while preventing institutions and individuals from discriminating against those whose consciences differ." [20]
	Justifying professional CO (+ 3/− 3; rm.:9) [PR]	"A final variation concerns public attitudes. If the community is deeply divided over whether a form of health care involves a serious wrong, there is a powerful argument that no individual or institution should be required to provide it." [15]
+−: Broad reason with equal amount of narrow reasons for and against CO	Organisational ethics require consideration (+ 1/− 1; rm.:2) [PR]	"Organizational ethics is a systematic examination of the morality of collective actions in human institutions dedicated to some specific purposes in society. The ethical "code" or commitment of a specific institution is now customarily expressed in its mission statement. This is in a way the "conscience" of the institution." [17]
	Legality argument (+ 2/− 2; rm.:14) [LR]	"Ultimately, there is no real possibility of engaging in the conscience rights discussion with total deference to the law because the discussion is precisely about what the law should be. In the end, the legality argument is tautological and fails to advance the claims made by forced-access advocates."[23]
-: Broad reason containing predominantly narrow reasons against CO	Requirement to offer a service (+ 1/− 2; rm.:11) [MR]	Already we hear ethicists suggesting that physicians must separate their personal moral beliefs from their professional lives if they wish to practice in a secular society and remain licensed as fully functioning physicians. [17]
	Institutional refusal (+ 4/− 10; rm.:23) [PR]	"When an entire institution refuses to deliver common medical procedures, like contraception and abortion, the risk to patients is further magnified. First of all, access becomes a more significant issue. Patients' choice of a healthcare facility is more limited than their choice of an individual doctor." [22]

Broad reasons used to argue for or against CO		Example of reason mentions
	Degree of involvement among HCP is different (+ 1/− 2; rm.:5)[PR]	“The intrinsic relevance of degree of involvement is more debatable. According to most people’s ordinary sense, if a person’s job calls upon her to receive answers from questionnaires that admitted patients have answered and to exchange a few words with those patients, an objection to such contact with the patients who happen to be entering to receive abortions would be unreasonable.” [15]
	Religious toleration has multiple dimensions (+ 1/− 2; rm.:3) [RR]	“Moreover, secular religiosity, which supposedly tolerates differences, does so only within a narrow range of so-called “values” that are supposedly “free” of religious or religious taint. But secular religiosity is itself an orthodoxy. Its “values” are based in democratic procedures, personal preference as the basis for religious choice, commitment to a free market economy, the commodification of health care, and an eschewal of religious belief. To deviate from this notion of religious “neutrality” in public policy is to be “undemocratic,” prejudiced, and intolerably sectarian.” [17]
- -: Broad reason containing only narrow reasons against CO	Imposing own beliefs (+ 0/− 2; rm.:7) [MR]	“The “Imposing Your Beliefs” Argument Imposes a Rejection of Hippocratic Principles.” [23]
	Critique of the conscience clause (+ 0/− 2; rm.:2) [LR]	“Immunity goes far beyond what is necessary to protect the moral integrity of medical providers. It destabilizes the medical profession’s duties to do no harm and respect patient autonomy. It endangers the very trust upon which the profession relies.” [22]

Appendix 10: Spectrum of CO Views

Participant	View
Betsy	*passionate about women's choices and advocating for women, beliefs are that I was raised in a church*
Gillian	*that's what the woman chooses to do, the medical side of me will have to stand there saying that*
Hannah	*I am somewhere in the middle*
Catherine	
Nancy	*I do believe it' s the woman choice. Pro-choice.*
Karen	*hoping she would be respectful of anybody who had a conscientious objective, but at the end of*
Emma	*Pro-choice*
Anna	*I wouldnt put my personal views onto others,*
Maria	*I wouldn' t object if that meant wellness for a woman. No, I wouldnt object*
Jane	*I just did my job! My role, my job was to support*
Dianne	*Its their choice as well as the woman's choice*
Ivy	*I don' t like to think of anyone dying, grey area.*
Laura	*I think its your choice. Its your body. You don' t have to answer to anybody; the trauma women*
Francesca	*I'm again forward as much as I' d say I'm open-minded. No, it's all about, you know, it' s about a*
Peter	*You almost shouldnt impose your theoretical positions onto someone else*

Anti-Abortionist/CO Absolutists ←— Accommodation —→ Pro-choice/Abortion defenders

Appendix 11: A Case Study: Ana Maria Acevedo

In September 2006, Ana María Acevedo, a 19-year-old and mother of three children, went to her local hospital due to dental pain. After carrying out extractions and tests, the patient returned in October with a facial swelling. After undergoing more tests, Ana María was referred to specialists for an evaluation and was sent to JM Cullen Hospital in Santa Fe. She was diagnosed with cancer and referred to the Iturraspe Hospital for oncological treatment. In November they planned to treat her with chemotherapy but discovered she was 4-5 weeks pregnant.

Without informing Ana María or her parents that an abortion was a legal alternative in order to begin treatment for the cancer, the doctors said they couldn't do anything because pregnancy was a contraindication for carrying out the treatment, and chemotherapy would have harmful effects. They did not give Ana María any medication or treatment, despite severe pain in her face and neck, and despite the fact that she and her mother repeatedly requested that the pregnancy be terminated so that they could treat her. (Later, the Minister of Health and the doctors falsely claimed that a termination had never been requested.) At the parent's request, the doctors involved the hospital's Bioethics Committee, which said life-saving treatment could not be carried out because the patient was pregnant, and in answer to the question, Has a therapeutic abortion been considered at any point? replied: "Due to the beliefs and religious and cultural tenets at this hospital (and in Santa Fe), no." Now desperate, Ana Maria's parents spoke to the hospital director who told them they had to get a court order for an abortion. The family also requested help from the ombudsman's office, but no help was provided. The lack of services caused intolerable, intense pain as well deformation to her face that was spreading to cover her entire face and neck. Ana Maria's health continued to deteriorate and she only received treatment for pain.
On April 26, 2007, when Ana María was 22 weeks pregnant, doctors decided to perform a caesarean section because she was "pre-mortem, that is, with marked respiratory failure and organ failure, and everything indicated that the outcome was imminent." The baby died within 24 hours. After a rapid deterioration in health, Ana María died on May 17, 2007. After her death, her parents launched a lawsuit, and the court convicted the doctors involved for the crimes of negligent injuries and non-compliance with the duties of a public

official, setting the precedent that not practicing a legal abortion may constitute a crime.

Appendix 12: Case Level Pen Portrait 'Thumbnail' Summaries

Order	Pseudonym	Date of Interview	Duration	Case Level Pen Portrait 'Thumbnail' Summaries
1	Anna	11/10/21	34m 3s	Despite starting her career spanning decades, Anna, a white, British middle-aged, nurse-midwife has limited experience of conscientious objection but her transcript is still valid because of its usefulness in 'setting the scene', especially in terms of the Professional Midwifery Advocate (PMA) role. Her 'gut reaction' responses highlight some of the reservation around support that objectors may receive, and she is sceptical about the effectiveness of managerial infrastructures. She contextualises the changing role of the midwife, outlining some functional tasks relevant to participation in abortion / duty of care and just how evolving this can be. Brought up as a Roman Catholic (RC), albeit now non-practising, Anna's comments pre-understandings and 'pro-choice' views are not typical of RC teachings, but demonstrate nonetheless, an appreciation of the theological questions raised in conscientious objection. Largely, non-objecting, Anna 'wouldn't put (her) personal views onto others. Depending on what the woman needed at the time, (she) wouldn't have any particularly strong beliefs, either way' (lines 61-62). Midwifery principles of woman-centredness are integral to Anna's testimony, which recognises the need for accommodation and respects tolerance of attitude.
2	Betsy	17/10/21	48m 37s	For Betsy, as an advanced midwifery practitioner third trimester scanning, ultrasonography, non-medical prescribing and scoping changes in practice forms part of her experience. This abortion-related role has involved a number of CO activities such as reallocation of objecting staff, dealing with abnormalities in pregnancy, supporting choices and acting as the woman's advocate, though she would not actively seek an abortion provider's role in employment. 'Raised in a church' (line

				65), posed Betsy ethical dilemmas 'in the very early part of (her) career, (she) did struggle with that' (lines 66-67), suggesting CO attitudes can be fluid and unfixed. Safeguarding similes enhance the reader's understanding of the difficulties of impartiality. One of the strengths of Betsy's transcript is her analysis of the causes of CO, particularly within multi-cultural settings, the medicalisation of childbirth and how this materialises as CO in practice. On the whole, her views are tolerant and accommodating, 'a very balanced way for a midwife to be' (line 261). She uses a linguistic analogy of compartmentalising perspectives into boxes (lines 238-239) to describe her neutrality and coping mechanisms.
3	Catherine	25/10/21	37m 10s	The most senior and long-standing midwife of all participants, Catherine has direct experience of supervising objectors as a white, British Midwifery Matron. The accommodation data she provides is rich and illustrative of CO in practice, especially amongst bank/agency staff in participation. She comments on the changing midwifery role and evolving attitudes to CO. It used to be that 'you were made aware that you could, um, object. You are also made aware that actually, that was not a great way forward - that actually these women needed your care, and you were almost withholding treatment. So, there was a recognition that you could. But as a midwife there was also, the….assumption, or intimation, that you knew what you were signing up for so, basically, yes you can object, but what are you doing in the role, if that's how you feel : that was 80's, late 80s.' (lines 73-77) to now, those objections at all levels, 'being heard' (lines 90-91). Challenges of the 'pull from the workload infrastructure versus the individual's needs (lines 93-94) include preparedness for employment, for example. She provides the clearest definition of participation, in which her ANDU experience comes to the fore in chaperoning, counselling and medical assessment prior to abortifacients. Prioritising availability, accessibility and woman-centredness choices, Catherine acknowledges practitioners' needs may fall secondary. She states, 'the bottom of the heap is what

				the midwife wants or believes or feels comfortable with' (line 187). In terms of declaring CO, she describes the 1967 Abortion Act as 'good enough', placing the onus on the individual (lines 202-203). Good insight is provided into the traumatising effects of CO on the women in the complaints she has handled. She mentions the unfavourable employment position of objectors, who she suggests could feel disadvantaged at job interview especially in preceptorship. Catherine talks of abortion taboos and bullying. CO is not 'a regular topic of mainstream conversation' (lines 285-286) though she remains hopeful that more supportive tearoom conversation around sexuality and the PMA role under the A-EQUIP Model will help open up discussion. A growing appreciation of rights in education, beginning in schooling, which equally incorporates sex education and contraception, she sees as one factor that will lead to a greater tolerance.
4	Diane	26/10/21	31m 37s	Diane remembers a striking CO scenario which arose in the course of her training, whereby a fellow student nurse conscientiously objected. In her current role as a sexual health practitioner, Diane has encountered abortion decision-making, counselled patients, referred, advocated, and facilitated informed choice in women's reproductive healthcare. Diane has a legal appreciation of the controversies surrounding CO in general and an awareness of the term 'participation', which she defines as, 'anything: any part of the care you know you could do. As you say, it's very personal… really a broad spectrum' (lines 78-81). In fact, elements of the clinical tasks constituting participation are covered extensively in her nurse-midwife's capacity. As a Catholic, Diane reminisces on 'the way we were taught in terms of sex education whilst in school of Irish heritage – that termination on any grounds is wrong' (lines 97-98). Through her account of the influence of Society for the Protection of the Unborn Child (SPUC) on her thinking, she explores how her views on abortion have 'changed massively now' (line 94). To this end, her

				position is ‘very pro-choice.... very pro-woman, now’ (line 117). Despite her general support for The Abortion Act, she questions the role of government when she makes international comparisons. She is aghast at discrepancies between American States, ‘how can they have centralisation over women’s rights? Choice over their bodies?’ (131-132). Rape and criminal abortion feature, in her highlight of case-by-case points. In respect of the idea of personhood, she argues ‘it depends on how you view life – does it start from conception or is it from gestation?’ (lines 150-151). Professional Codes of Conduct and the importance of ‘working within the parameters of the law (lines 256-258) do feature, as well as the challenges, in Diane’s transcript. She touches on gender issues/paternity rights, but her position is stalwart, “Ultimately it's the woman's choice.” (line 197)
5	Emma	10/11/21	30 m 3s	Emma has extensive experience as a nurse-midwife. The legal requirements if it’s an emergency situation to look after the lady (lines 22-23) form part of her definition though she acknowledges poor understanding of the concept due to her limited experience of CO. Her views of the midwife’s sympathetic and supportive role are central to Emma’s opinion of objectors. ‘It’s a really difficult decision to have a termination anyway. And the lady has obviously thought long and hard about it. I don’t think there’s an easy way out...you’ve just got to support as best you can really.’ (lines 47-50) Her pro-choice position features alongside Emma’s alignment to non-discriminatory care. She reflects, ‘who are we to judge another person? (line 55). Participation means administering the drug in the actual act of feticide, an act that believes Emma suggests people may understand better case by case if there is a fetal abnormality (lines 91-92). She contextualises the Paternalism of professionals, in terms of patients’ expectations and health-seeking behaviour, ‘Yeah people know their rights these days. Whereas years ago people just used to nod at the doctor. Now they challenge the doctor.’ (lines 204-205). The rights of other professionals (e.g. pharmacists and maternity support workers) is touched upon, as part of ‘the hospital team’. Interestingly, Emma

				says one of the impacts of CO on the woman may be getting 'vibes off nursing staff' (line 149), suggesting a subliminal communication of CO, implicit and understated. However, most of her colleagues tend to 'put the position of the lady uttermost' (line 162), although she recognises the taboos. Arguments around bodily autonomy, including a feminist argument on the matter also arise in Emma's transcript.
6	Francesca	10/12/21	29m 52s	As the only abortion-provider and previous Trade Union activist, Francesca demonstrates an appreciation for employee rights straight away and abortion-support 'without judgment ' (line 23). The discussion moves quickly to women travelling from Ireland seeking health services. She expresses the effect of her personal circumstances on her career choices, losing a boy at 32 weeks gestation and her CO position is influenced henceforth, 'you've lost a baby - how is it that you could support these women to terminate a pregnancy? Because it can…because it's not about me … and that's very much how I feel about conscientious objection: to the midwives that feel strongly enough about this subject – "Well, that's great". That's on you, you know, if you feel that strongly about this subject, and you feel the need to take a step back, that's fine, that's OK, because that's your human right.' (lines 53-57). The perfunctory nature of participation 'that's my day job' (line 108), does not deny that Francesca cites dilemmas she feels, mostly related to gestation and timing, 'every woman has the right to choose. But for me, I don't think I feel comfortable in supporting a woman who's coming up for the limit of viability' (line 118-119). Francesca nonetheless admires objectors – 'well done, for saying, 'actually, I'm going to hold my hand up and go I can't do this !' (line 155). She is savvy on modernisation of processes relating to medical assessment of the Abortion Act's criteria, its liberal nature and the protection this provides for practitioners (lines 179-186), albeit extending. Induction of labour is the only context Francesca received formal academic input about, with no formal education on CO. As regards impact,

				Francesca's first thoughts are with the midwife and the 'internal conflict' (line 212) it can cause in addition to the 'terrible' way it make the woman feel. Staffing is the primary way Francesca feels the situation could be improved.
7	Gillian	4/1/22	44m 49s	Gillian sees dual training as significant since in Gynaecology nursing, she gained experience in dealing with patients' consent, advising around early pregnancy choices, and managing expectations. Gillian data mentions risk, governance, and legal expertise. The focus of her work is particularly on breach of duty, examination of serious incidents, themes and trends of claims and risk management, "So that we can share some learning with the wider clinical community." (Line 29) The phrase 'two hats' originates in Gillian's transcript. The discussion starts with Gillian's ideas on when life begins (at fertilisation) and how this may differ from medical age of viability in comparison to legal definitions. Her accounts of colleagues who've left the profession because of CO show the seriousness of the questions raised in workplace practices. Empowerment is very important to Gillian and as a Caribbean nurse-midwife, the Feminist, intersectionality insight provided is invaluable to a broader look at contentious issues.
8	Hannah	18/1/22	51m 17s	An 'all-rounder' (line 15) agency midwife, having secured and declined a post in an abortion clinic, early on, Hannah describes herself as 'somewhere in the middle, I would say' (line 52). Her standpoint is perhaps reflective of her Asian ethnic origins and personal family experience of maternal mortality due to the complications of unsafe, illegal abortion. She herself has never objected, 'I've not actually said no to giving the medication...because it is actually up to the woman what they want to do, how they feel about the abortion, which I think is not my...it's not up to me. It's for them to decide that' (lines 28-30). Whilst a Muslim perspective is acknowledged, her views are very personal. She does express her reaction, sometimes thinking, 'Oh my God! What have you done?! (line 48). Discussion on availability and accessibility of services begins with a historical,

				backstreet abortion context, when Hannah questions, 'that will happen if it is stopped by the NHS' (line 71). Beyond safety, respect for differences features in Hannah's transcript. Her main experience and understanding of CO relates to doctors' refusal to 'sign the paperwork '. Wider support for an abortion system and more specifically referral in such cases is practicably discussed, including one idea to have doctors open advertise their CO position to save time in early pregnancy. In light of this, emergency care is ethically and morally reasoned, 'I think everybody would go in an emergency scenario, so and I've not met anybody that strictly saying 'No, I'm sorry I'm not doing that' (lines 162-163). Her information is scanty on the legal term 'participation' (not unlike other participants) but her opinions are fairly presented and the insight provided thoughtful, particularly on the impact of CO. Like many participants, Hannah has limited experience of social abortion, which she sees as midwives' prerogative to decline, 'I think as midwives, I think most will refuse to have that on their conscience,' (line 202) she says, if social abortions were undertaken by NHS staff. The status of women, patient expectations and societal changes because of improved education and multi-culturalism, are discussed against a background of contraception.
9	Ivy	16/3/22	42m 56s	As a Practice Education Facilitator, Ivy is well placed to discuss learning on freedom of conscience. The focus of Ivy's discussion centres on screening and fetal medicine predominantly (e.g. Downs' syndrome management) and ante-natal diagnostic screening (Harmonie tests), about which she is knowledgeable as a previous research midwife. She describes herself as 'pro-choice' (line 75). Implicit or informal CO amongst colleagues is the bulk of her experience. A rich metaphor, of 'worrying that when I get to the pearly gates, I don't know if God will kick me out because of the things I've done' (lines 78-79), appears in Ivy's comments on the religious nature of freedom of conscience based on the commandment, 'Thou shalt not kill' (line 151). Ivy also provides a descriptive 'Call the Midwife' (line 133) account of elderly relatives' faith in medical professionals,

				and their Paternalism, which serves to contextualise the debate historically. Her comparison to a current rights-driven/expectation-led climate relates to information access through use of the internet. Her scenario example of a uterine cancer sufferer and her abortion decision-making is most insightful to moral reasoning. Ivy suggestion that signs of life in a premature or aborted newborn should be managed in the manner of 'do not resuscitate orders' is interestingly poignant.
10	Jane	25/3/22	1h 8m 14s	Jane has acquired vast and varied managerial experience e.g. dealing with complaints, employment contracts, occupational health and well-being. She comments on an enjoyable career as a nurse-midwife, a Birth Suite Coordinator and as a Matron. Keywords in Jane's transcript include the phrase 'to compartmentalise professional personae and personal personae' (lines 33-34). Her one exposure to CO, where Jane 'came nearest to questioning somebody's decision-making' (line 67) centres on a case where the woman opted in favour of abortion after IVF treatment due to XXX syndrome which would have rendered the infant taller than average. She describes herself as a non-objector but does mention timing and gestation dilemmas. A lot of the discussion focuses on informed choices and empowerment.
11	Karen	29/3/22	42m 33s	Karen 'has done lots of varying jobs' (lines 11-15). Being a Birth Suite Co-ordinator has brought her to encounter some CO scenarios, mainly amongst colleagues, though she has experienced some dilemmas herself – notably in resuscitation. As a Matron, Karen is involved in improvement projects (such as ward accreditation). As such, some of Karen' managerial insight is invaluable: on initiatives like benchmarking, audit, dealing with the Coroner's Court and the role of Healthcare Safety Investigation Branch (HSIB), both within and between Trusts. CO professional matters, such as duty to refer, taking consent, staffing, admission of patients, what constitutes participation and tribunals are among the strengths of Karen' data. Proactive patients groups, empowerment, shared decision-making, and contemporary expectations help contextualise the debate. Issues of safety, in

				terms of unsafe abortion, health tourism, telemedicine and postal use of the morning after pill are mentioned also. The importance of private provision of abortion services, as specialists in reproductive health is reiterated. Screening for fetal conditions and the eugenic quest for perfection are touched upon. A Feminist theme of empowerment surfaces periodically. When asked how she herself would describe her own objector/non-objector position, Karen replies, ‘somewhere in the middle’ (line 183) and this she relates to her own birthing experience.
12	Laura	11/5/22	1h 3m	Laura provides rich and plentiful data, particularly on the ethical dilemmas raised in diagnostic screening associated with disability (hydrocephalus, Down’s, Patau’s, and Edward’s syndromes feature in the transcripts). Powerfully, she cited a travelling family’s remarks - ‘You are talking about murdering my baby, aren’t you?!’ (lines 53-54). A lengthy and varied career makes for some in-depth and thought-provoking comparisons between health systems, including on the provision of contraception. A pro-choice advocate, she herself has participated in all aspects of abortion, yet recognises the dynamics of accommodation and the consequences of differing actions of her objecting colleagues. Of all participants, Laura forwarded real-life scenarios of ethics-based, abortion decision-making in the service-users she has cared for, especially in relation to social justifications and moral reasoning, “‘I don’t want to be pregnant I don’t want to be pregnant! I’ve already got one child involved with social services and I don’t want to be in that situation!’ (lines 67-69) …I just felt sad that she had enough on her plate and she was getting … *(hesitates)* getting resistance from people who I thought would help”. (lines 82-84). Her insight into the reversal of the legal decision made in the case of Roe versus Wade is interesting since, although UK trained, Laura has practised as a midwife in USA.
13	Maria	12/5/22	44m 43s	Maria’s insight as a white, Britsh, practising Roman Catholic is invaluable. However, her neutral view supporting women’s choices, whatever the circumstances, is unusual. Interestingly, her

				abortion position has changed from her upbringing. Her perspective on power in communities, authority and societal attitudes is very thoughtful. Although true to RC teaching on when life starts, “Personally- that’s my view: sperm meeting the egg” (line 345), she echoes the theoretical ideas of Jarvis-Thomson, “I totally see that but a baby is *housed* in somebody else’s body and they’ve got the right to make decisions about what happens. That’s the way I see it.” (lines 334-335). She sees the functioning of handover, rather than a register or in taking up employment as the way forward and suggest it is the Band 7 role that is pivotal in CO. With lots of midwifery values expressed, she is a passionate advocate for the woman.
14	Nancy	19/5/22	52m 50m	Most recently qualified, Nancy voiced no conscientious objection and described herself as pro-choice. She has no experience of conscientious objection but gives an accurate definition as she gained insight from her recent midwifery studies, where the topic was covered in relation to antenatal diagnostic screening. Her eligibility criteria was substantiated by her expression of the dilemmas she herself expressed in relation to gestation, and thereby viability – her lived experience, in Heideggerian terms. She gave particular insight and awareness of feminist issues and her comments on paternity were interesting. Nancy was unsure of a policy on conscience existed within her institution, though she was aware of her rights, if never actually exercising her freedom of conscience. Her professional views were in keeping with her personal stance, unlike other participants. She talked extensively and hypothetically about effects or the impact of CO, but only touched on causes. Her own CO position is described as one which is both a personal and professional view converged, “I do still believe that it’s the woman’s right. Erm, but a late gestation, depending on the reason, I suppose is a little bit more difficult...it’s hard at a later gestation. I want to support somebody in their choice, but I don’t think that I would conscientiously object to her decision.” (lines 33-36)

| 15 | Peter | 25/5/22 | 1h 26m 13s | The only male participant in the study, and as an educational professional, Peter's insight into the learner's experience is invaluable. Indeed, his solutions for improvement to the situation centred on the educational curriculum, nurturing future leaders of the profession as a means of facilitating policy. As the final interviewee, a lot rested on Peter's perspective. The substantial quantity and quality of data yielded covered all CO issues as well as touching on professional midwifery matters. After a succinct but precise definition, Peter elaborated ably on the causes and justification of CO, as he sees it, outlining his own view of rights to bodily autonomy. Although, like Maria, debate ensued around the use of "weaponised" and "politicised" pro-choice terminology, he stated his position of non-declaration of CO. As a practitioner who has participated in abortion procedures, however, Peter expressed a lived experience of dilemmas, "I did have to really think about it'. Gender issues unsurprisingly feature heavily in Peter's transcript. Data provided is contextualised to current understanding of the midwife's role and function within the multi/inter-disciplinary team. Peter talked of busy booking clinics, where referral networks commence, CO declaration emergencies and dilemmas related mostly to fetal abnormalities, also covering when life starts and fetal rights. The "messiness" of ethical decision-making, not least in employment, are mentioned, though ethical principles surface throughout the text, including accountability, informed choice equity, justice and fairness which provide a focus for Peter's own take on how one cannot shy away from one's own responsibilities. One of the themes is moral complicity, for example. Peter's acknowledgement of the emotional burden of participation is rich in linguistic metaphor alongside practical instances of CO in action. Her impressions of the 1967 Abortion Act and the theoretical background cited of the feminist movement in defence of abortion rights provides an interesting and well-articulated 'different voice' in a study comprised mostly of female participants. Current |

				affairs in America and Afghanistan are mentioned, to discuss human rights and women's healthcare.

Appendix 13: Transcription

Interviewer: Thank you for joining us today and for the interest and support you have shown to what we are trying to achieve at the Conscientious Objection to Abortion Project.

Interviewer: just for the benefit of the tape: you've received a consent form (which is signed)?

Karen: yes I have.

Interviewer: and you are happy to be recorded?

Karen: yes, I am.

Interviewer: perfect. Just as an ice-breaker, to set the context a little bit, Karen, can you please clarify a little bit about your career to date and your position at the moment…?

Interviewer: fantastic service and experience. In terms of our aims and objectives in this research, have you come across conscientious objection in that time?

Karen: yes, I have. Some of the doctors, for cultural reasons, have shown objection to termination of pregnancy (or abortion) actually on Labour Ward. This was overcome by asking other members of the medical staff to be involved. Erm, so the job was done....and the continuity for the patient was not affected by that. However, it did mean that it was *another* job for us to do – to find another member of the medical staff to sign the paperwork and consent form etcetera.

Interviewer: yeah. They are following their professional guidance, in that there is a duty to refer so the patient is not affected (and sometimes isn't aware).

Karen: that's right.

Interviewer: in that case, was the lady aware that there were professionals who were objecting?

Karen: no. No.

Interviewer: ok. Just as a benchmark, can you tell me what you understand by the term 'conscientious objection', please?

Karen: that's when you have a strong enough feeling to prevent you from taking part in somebody's care, proceeding with something that is an integral part of your job.

Interviewer: thanks for clarifying that. On a personal level, can I ask what your view of conscientious objection is? You are not at liberty to answer, you can decline any of the questions, if you don't feel comfortable and you will get a chance to review all your responses before anything happens. All data will be anonymised.

Karen: what was the question again?

Interviewer: on a personal level, can I ask what your views are on conscientious objection?

Karen: I think everyone has to be treated as an individual - if they have an objection which can be facilitated within the job that you are doing. It becomes a problem when lots of people have an objection and the job is affected as a result. Over the years, we have noted that people are more direct in objecting to do things. Erm...and it may in the future become an issue. We haven't reached that point yet, or I haven't become aware of it being an issue certainly within my field of practice, but I can imagine that if you were in areas of higher cultural numbers, it may be an issue, you know? If you go to some of the inner cities where culture is...where there are lots of ethnic groups etcetera or cultural groups, feelings could impact on the numbers objecting, where people are declining to do certain aspects of the work, it could impact on the care we provide for women.

Interviewer: I suppose, a lot of people have said about culture...hmmm, I suppose it depends on what you consider to be the causes of conscientious objection. Have you any experience?

Karen: I've only had experience of a cultural objection, really, without knowing others. I mean, may not be able to think of others off hand, really. Its a cultural thing,

Interviewer: do you mean in terms of religion?

Karen: yes.

Interviewer: because it's not exclusively a Roman Catholic thing. It could be Muslim, or Jewish and even some Humanitarian people can object, for different religious or solely conscience reasons.

Karen: yes.

Interviewer: erm, can I ask what you understand by the term 'participation' in abortion please?

Karen: anybody who has anything to do with that, whether it be somebody you are looking after, or signing a consent form agreeing that that is a good plan, yeah: anyone who remotely takes part in an act of abortion.

Interviewer: yes, because this term has come up in some of the legal cases, where the service has changed around midwives and the context of their job, their role or the tasks they're doing has changed. They've asked in some of the court cases, for closer clarification as to what people can object to and when. As you rightly say, it means different things to different people, depending on your views.

Karen: I must admit, the different Trusts behave differently. You know, whether patients are going through a social abortion: whether they would be on a gynae ward or whether they'd be on maternity. It just depends on which Trust, whether you have a gynae ward that's linked to your maternity unit, it may be that you have midwives involved in social termination. That then would determine whether they would be on the gynae ward or on maternity. At the moment, in the Trust I work in, we are only involved in the therapeutic termination or abortion for abnormality – the area is quite different in that aspect.

Interviewer: yeah. I think that is part of the inconsistency, that although we've got *National* health service, it works very differently with different regions, like different countries have different laws, as well.

Karen: that's right.

Interviewer: at the this end of the wedge, if you're faced with a lady asking you for something that you disagree with, it can be a bit controversial.

Karen: yeah, there is, I have always found that I could find someone to help in that sort of circumstance. I've never been in a position where I've not been able to help, or assist the patients we are looking after. I'm fortunate in that respect. I'm sure there are times, when there are lots of objectors, you know, to what a patient is requiring, so there may be issues there.

Interviewer: I think we are very privileged in this country that most of our abortion services are provided *privately.*

Karen: that's right.

Interviewer: ... so it's a highly specialised field of reproductive health.

Karen: yes.

Interviewer: so like a hairdresser who may be allergic, I don't know, to say hair dye, they don't go for that field for that reason. But some of the changes, just to bounce some ideas around with you, if that's ok?, that have meant that midwives have faced different challenges since the 1967 Abortion Act. So for example, when units have configured, with the extended role of the midwife and how patients may be different now, with different expectations. Do you think in your long career, that the nature of the job has changed?

Karen: definitely. Women are more empowered to speak their mind and they won't just put up with whatever we are saying. They're as knowledgeable in some aspects of their care as you are. Women do read around the subject and they come forward with some quite difficult questions sometimes.

Interviewer: I think we are more politicised, I feel.

Karen: yes definitely. And that's the name of the game at the end of the day: to speak their mind and to be proactive in their care. You know, we're involving women in the change process and in decision-making from a very early onset. With Trusts, it's going that way – and it needs to, for very good reason: to involve all our service users in the process. It's a definite good thing to happen is to involve all our service users in the process**.**

Interviewer: yes, to share the decision-making and to take account, isn't it, for their care?

Karen: yes.

Interviewer: but this has lead to some dilemmas that are cited in the literature. What do you think, even if not you personally, what do you think that they might be uncomfortable with, or in moral distress with about the actual abortion process?

Karen: where it's carried out, might be the first thing. Like I've just said, it might be a gynae ward in some areas which on the general side, on the nursing side, is very different than maternity, looked after by different people. Erm, they may have objection to who is looking after them – they may want a midwife! Erm, they may want a nurse, depending on how the pregnancy is (if they've considered it be a pregnancy).

Interviewer: what does that mean, (if they've considered it be a pregnancy), to go to full-term with the abortion decision-making about the pregnancy?

Karen: yes, a possibility – it depends on the gestation at the time of abortion.

Interviewer: yeah. You're right, it's very much about power, isn't it in that sense and sharing the conscience.

Karen: yes.

Interviewer: There are also more, wider professionals involved in providing the service, now. So example, with telemedicine, posting mifepristone and misoprostol, can't even say it properly now! But some pharmacists are saying that they have conscience rights too, particularly in different countries, say in more Catholic countries. I don't know how you feel about that?

Karen: I think it should be monitored. It's alright giving people medicines but we need to monitor progress and the effects of those medicines. You know, a) whether they've taken them (you may have someone who doesn't necessarily take their medicines as prescribed.) In the hospitals, we are quite strict on taking them, when its prescribed, then what you move onto. We have a protocol and guidance that tells us: what we need to do at certain times. Whereas patients left to their own devices may not follow that particularly well.

Interviewer: yeah.

Karen: I mean, we may not be dealing with something that hasn't worked or has been failed, but it's not because they've not had their medicines but not taken them correctly or....

Interviewer: yes. Or because they've been devious in how they've taken them because for me personally, one of my ethical dilemmas is that its not a perfect science, is it? Determining gestation....

Karen: that's right and how can you be assured that it's that actual person who has taken them? And they've not got them for somebody else?

Interviewer: yeah.

Karen: we are very clear when we're giving out medicines to patients: checking ID and that it's prescribed for that patient. You know, if you're going to be sending out medicines to a patient to do it, then, in another location, it may not be followed as strictly as that.

Interviewer: yes. And of course, it contradicts the 1967 Act, which to address backstreet abortion, the law in 1967 said it must be in a registered healthcare outlet.

Karen: yeah

Interviewer: .... and what about the implications for safety. I worry about that, I do. Erm, ok so is there a policy on conscience in your institution?

Karen: not that I am aware of?

Interviewer: do you think it might help?

Karen: yes. I think so, definitely. *(pause in conversation)*

Interviewer: some organisations, particularly the Catholic hospitals in the States and stuff, have ethical committees to review cases like this. How do you feel about being held to account in a tribunal situation, for your clinical decision-making?

Karen: erm, I think it will come. It's only a matter of time. I think it's going very much like that now.

Interviewer: so, at the moment, the onus is on the practitioner to declare the objection beforehand, so, for safety's sake, people can organise the cover of the service – to ensure access and things. Although they must declare beforehand, they don't have to say *why*.

Karen: right.

Interviewer: I wonder if an open forum might help support them (*practitioners)* in their decision-making or whose benefit a tribunal system may favour?

Karen: possibly. That would be a benefit. Whether they would be penalised by voicing their opinion or....I'm not so sure.

Interviewer: It's a taboo isn't it? And there's a lot of pressure to be the perfect employee, isn't it?

Karen: that's right.

Interviewer: all things to all people.

Karen: *(both laugh)* that's right. If you start putting up the barriers at interview, that might go against you, especially in areas where they struggle. I mean, I'm not in a position where I struggle, having practitioners to participate. But in others areas where they *do* struggle, to have an employee with a conscientious objective that might be something. Although they can't say that, if it's not stipulated in the job description, they're on a sticky wicket, really, on that one.

Interviewer: yes they are really, because it's legal to conscientiously object. Section 4, part 1 of The Abortion Act says you can have a conscientious objection, but the

professional guidance is a little more ambiguous. Can we just think a little bit about the way the law works, if that's OK?

Karen: yes

Interviewer: do you think that the 1967 Abortion Act protects midwives' rights?

Karen: yes, to some extent. Obviously we are protected – but does it stipulate midwives or does it just say it needs to be carried out in a healthcare setting?

Interviewer: That's a good point, actually. That's one of the reasons we have been asked to look at it: that most of the conditions of the 1967 Act cover doctors because they're the ones participating in the feticide bit.

Karen: interesting.

Interviewer: Yes, it is isn't it? There are four conditions that you can have an abortion in the Abortion Act. Sometimes people object to one reason, but not another. Do you feel that it should be a legitimately endorsed and an available service *for everybody?* Or would you stipulate conditions? How would you describe your own position- as an objector, or as a non-objector?

Karen: that's right. erm, I am probably in the middle because I wouldn't like to think that it was done as a matter of course. There has to be serious consideration and it has to fit inside one of those four categories. I think if you take away the strictness of it, then it may lead to more intervention s that shouldn't have happened. You know, you don't want it abusing: the system of unwanted pregnancy. If they feel they can abort a fetus, it shouldn't be as freely available as that. However, I feel that there are 4 criteria – we've already got the guidance, erm, and I think it supports what we currently need.

Interviewer: yeah. Because nobody is asking to go back to pre-1967 backstreet abortion. Heaven forbid that public safety becomes an issue again! There are so many changes afoot, that people have said it's very conservative, Victorian-type law, for dealing with offences against the person: that it could do with being updated, even in a British context....erm (sorry, I am just reading my questions! With my new glasses, I can't see a thing ! *(Both laugh).* I'll have to take m'glasses off!)....okay, so can you tell me what you think might be the effects of conscientious objection? We've talked a little bit about the causes, now let's think about the impact of conscientious objection, if that's OK?

Karen: so the impact is that you can't do the procedure because you can't authorise it happening. You might not necessarily get the support that's required, if somebody is objecting.

Interviewer: for me, the solution if manpower, it really is. It is a numbers argument – in human resources.

Karen: yes, definitely. I think to have the trained staff as well to deal with that. Most units have moved on and have Bereavement Midwives – but whether or not that's the right person to deal with this category of patient, albeit the numbers are relatively small, as such, it wouldn't be a job spec, as such with bereavement of any sort. So it would be fetal losses of any sort, as well as abortion patients, you know, termination of pregnancy whether it be for social or therapeutic reasons.

Interviewer: its all grief, I am sure it's all difficult. I'm sure it's not an easy decision to make whatever the circumstances.

Karen: I think to have trained people who are specialists in that field is definitely the way forward. I think all midwives are trained to some extent, however, I think for the service to be a good quality, we need to have experts to look after these patients.

Interviewer: .... and supported, you know? If we are asked to do difficult jobs in society, then who pays the hangman, in that sense? I feel myself you need more support for your ethical decision-making so you can support yourself, really. It's caring for the carers, I think there's an issue there.

Karen: yes.

Interviewer: how do you feel that the current law protects the women?

Karen: it does because it's quite restrictive. It gives them guidance on who will and who won't assist in abortion and what the criteria is. Its probably not that helpful to women, if they don't fit the criteria.

Interviewer: yeah. How do you feel a woman would feel if she knew someone was objecting to take care of her?

Karen: I mean, I'm hoping that she would be respectful of anybody who had a conscientious objective, but at the end of the day, she's there for a reason. It may not be an easy decision for her to make. There might be other elements that are forcing her to make that decision so hopefully she'll want somebody who's kind and compassionate

looking after her....irrespective of what their views are, they should be kind and considerate.

Interviewer: you can still be compassionate and ...*(gestures a boundary)...*

Karen: yeah. Irrespective of what their views are, they should be kind and considerate.

Interviewer: and objective rather than objecting. On our project, we've got people of all persuasions, really, and all different disciplines, with different standpoints on abortion. The point is, not the rights and wrongs of individual cases, but how to thinking about the problem-solving of conscientious objection and staffing. In Italy, conscientious objection is as high as 80%, whereas in other countries, such as in Scandinavia, it's not legal at all. Countries where they've eradicated Down's syndrome. You mention about chromosomal abnormalities and the ethical decision-making whether it's a therapeutic or a social abortion. Erm, we are doing more screening now, how do you think that may have impacted?

Karen: well, we are doing screening and giving women *the choice,* to abort at an earlier stage of the pregnancy, erm, if it wasn't going to be an issue (not encourage women to abort a fetus that was affected, but....) if we were able to give them a decision, why would we do the screening in the first place? The other flipside of that is if she's not going to terminate the pregnancy, she's got an earlier diagnosis of the fetus, for the baby when it's born, to deal with those issues. So the benefit of screening at an earlier stage is to give them more time to absorb that information and fuel themselves with all the information they're going to need for that specific abnormality, that condition, when that baby's born..

Interviewer: knowledge is power, again in that situation....and insight. It's about supporting them, I suppose.

Karen: exactly, yes.

Interviewer: I suppose it depends on your view of what's an abnormality, 'cos that's changed, hasn't it?

Karen: well that's right, it has changed.

Interviewer: I am asking some real toughies, here, aren't I?

Karen: I'm finding it clear in my mind, if I think what I would have done with my pregnancies had an abnormality picked up, because I did have screening. And I did have an amnio because I was over 40 and it came back as high risk. I was quite clear as

to what I would have done....and I'm a midwife. Would that be frowned upon by others? I have friends who have affected children, by trauma, the effects of longstanding birth trauma, colleagues who have allegedly 'abnormal' children, if we are considering abnormality...erm their decision was to continue with the pregnancy whereas I have quite strong values on that: quite strong values, thoughts on how I would have dealt with it. But I wouldn't castigate anyone else who was in a position, making the decision, who would continue with the pregnancy, knowing they had an affected fetus. That's just my choice as opposed to somebody else. You've got to consider everything else, the rest of your family, the siblings. There's a much wider picture – it's not just about yourself dealing with abnormality or affected children. It's a personal decision only you can make. Lots of people can give their opinion, to try and sway you. The idea is to give women the whole picture – good and bad – give them a full picture. Give them a chance to speak to affected children and they will give a completely different picture, I am sure, of somebody who has terminated a pregnancy.

Interviewer: I think you're right. That people in this job, distinguish between their professional views and then their personal views. Walk a mile in my shoes, would I feel differently if it was myself, or my friends or family?

Karen: that's right.

Interviewer: do you think there should be paternity rights in abortion?

Karen: yes, 'cos I think it's a joint decision. Definitely a joint decision. The difficulty comes when you've got, you know, one element of the relationship that does and another that doesn't- then you've got a real problem then. Then, ostensibly the woman who has to make the final choice therefore, as it's her who has got to go through it.

Interviewer: its would be interesting to get a male midwife's point of view, wouldn't it?

Karen: yes, but there aren't many about are there?

Interviewer: no, erm, just as an aide I feel we are not just caring 'with women', we are with families, I feel, aren't we?

Karen: very much so. Got to look at the full picture. In everything that we do or say: think family and involve the woman – think how the woman fits in with that family network. I mean, is she a carer for other siblings? A relative? Or parent? How does she fit in to that network of people around her? Dynamics have changed with family networks, they're very often not all in the same town....supporting. They may be from a different country for instance, so family aren't supporting at all.

Interviewer: then you get al.et all the cultural things you were rightly saying about, living in a pluralist society, as well, a little bit....

Karen: yes.

Interviewer: thinking about screening and abnormality, there was a lady who aborted because of cleft lip and palate, which I didn't see as a valid reason, but I mean, you can be pro- abortion and pro-conscientious objection at the same time, or object to one and not another, I just find it a bit torn.

Karen: that's not a matter of life and death, is it? You know, there's lots of good stuff out there and perhaps speaking to the right people may have helped sway her in her decision. It's about having the right people there, giving you the right information.

Interviewer: to me, it almost seems eugenic.

Karen: oh, that's a real toughie! It's...I wouldn't have said that was entirely fitting of the criteria, really.

Interviewer: but who are we to decide for someone else in a way isn't it?

Karen: well that's right. Is it a knock on to our perfect society, that we can't cope with something that is slightly imperfect? I think we are turning into a society that can make a decision and get rid of things that aren't perfect.

Interviewer: thanks for that. That's really useful insight. Could the situation be improved, do you think? Perhaps about tribunals, or a conscience policy or a change in the law? Is there anything you'd like to add on for the way the way forward might be, having recognised these issues in legal cases?

Karen: I think we are doing some good things in Maternity- discussing cases, live cases, that have actually happened....could we have done anything better and involving service users, in that table-abortion discussion. I think some of the investigations into what have gone well and what haven't gone so well, is where we are ahead in Maternity in some respects. We have external investigators that investigate things for us, setting a benchmark across the NHS....

Interviewer: sorry, I interrupted you then....

Karen: it's okay

Interviewer: the serious case reviews, whilst sad, still have their purpose. I feel we are better at auditing.

Karen: definitely and we are utilising our external agents – I mean we have got HSIB on board, too. You know – when things don't go so well, they are investigating independently of us. They will already have done, say a table-abortion discussion, or a serious case review, or a level 1, depending on what stage it is at....

Interviewer: *(nods)*

Karen: whatever case it is, whatever stage it's going through, we have external agents who will do a parallel investigation and they can cast light on (because they are dealing with different Trusts), whether that would have happened in a different Trust. That sort of thing: benchmarking against other units and benchmarking against other regions for maternity care.

Interviewer: and learning from initiatives, isn't it? Because I mean, you are right in that we are a flagship in maternity, working with the union role, as well, with a stronger union position, I feel, not to put too political a point on it. Can we just cover a little bit more about HSIB, because it's not something that I am very familiar with?

Karen: ok, HSIB is an investigation authority, or Board, who will do an investigation parallel to the Trust to see, for the openness and transparency. They will have been investigating similar incidents across different Trusts, so that they can benchmark against each other and also identify if it's a *regional* thing or if it's a local thing to a particular Trust. To compare the data, which hasn't been that readily available. We've all been quite insular in our investigation proceedings, we've investigated our own wrong-doings where things haven't gone quite as planned. We have investigated them internally, whereas HSIB is a *national* investigatory body.

Interviewer: I think that's really important if it's a criminal element we are dealing with, looking at unsafe abortion – the umbrella picture comparing between countries: some of the health tourism incidents that need prosecuting. Seriously held to account for the loss of life. The World Health Organization estimate that 19 million women annually are affected by the complications of unsafe abortion, so I think that's a really valid point. Are you happy for me to use a pseudonym? I'm using 'p' names for participant.

Karen: yes – Karen.

Interviewer: Have you got anything you'd like to add? Any more thoughts? *(interlude whilst Interviewer answers the doorbell)* well, perhaps one more question – you mentioned about gestation. Have you come across any resuscitation dilemmas at the cusp of life or...?

Karen: definitely. Erm, we've had fetuses that have shown signs of life, then it's all about what support do you give: I mean, is it a gasp or is it an actual breath? People misconstrue different things. Probably years ago, fetuses prior to the cut-off for gestation, well, the cut-off for life, if you like, were probably taken away from the mother and just left and not observed. But I think now, we are very much in the frame where we observe the fetus and get the mother's involvement. Irrespective of what's actually happening, they're more involved so that the view that you would pick up on things, that you would deem to think that there were signs of life. We have had many discussions about 23 weekers, that have showed signs of life and whether they *should* have been resuscitated when the paediatricians have said, 'No! Not for resuscitation! We are not doing anything'. Making quite a categorical decision, so that then a Coroner needs to be informed, if there are signs of life, to inform them that there has been a death.

Interviewer: yeah.

Karen: its a very grey area and it has had some discussions over the times on Labour Ward. Over the last ten years, I've known a couple of cases, that have caused a lot of concern, that have needed a Coroner, because the person at the birth has alleged that there have been signs of life.

Interviewer: yeah. It's very tricky. It's hard on the coalface, isn't it?

Karen: it is. Definitely.

Interviewer: Thank you for taking part in today's interview. I've got some valuable data and some enriching insight, its been invaluable what you have said, so thanks for that. What happens next, is that over the next couple of days, I will get this typed up and get it back to you, to review. Please feel free to make any amendments that you feel are needed. Thanks again.

Karen: you're welcome. Take care, bye.

Interviewer: bye.

Appendix 14: Abbreviations

ANP - analytical hierarchy process

BHA – British Humanist Association

BMA – British Medical Association

C of E – Church of England

CO – conscientious objection

D and C – dilatation and curettage

ECrHR – European Court of Human Rights

EMA – early medical abortion

EU – European Union

GET – group experiential theme

HCP – healthcare professional

HFEA - Human Fertilisation and Embryology Authority

HSIB - Healthcare Surveillance Investigation Board

IPA – Interpretative Phenomenological Analysis

IVF – In vitro fertilisation

NHS – National Health Service (UK)

PET – personal experiential theme

RC – Roman Catholic

RCM – Royal College of Midwifery (UK)

RCN – Royal College of Nursing (UK)

SRH – SRH

ABORTION – termination of pregnancy

WHO – World Health Organisation

Appendix 15: Glossary

Abortifacient - the medicines taken to end a pregnancy and induce abortion.

Abortion - the procedure to end a pregnancy.

Absolutism – a school of thought which holds that health care practitioners should be exempted from performing any action contrary to their conscience.

Accommodation – a school of thought advocating a conventional compromise approach that accommodates conscience-based refusals within the limits of specified ethical constraints Wicclair (2011).

Age of viability – the gestational age at which the fetus is said to be capable of sustaining independent life outside of the uterus. In the UK, this is legally set at 24 weeks.

Confession - examination of conscience, recalling sins to be forgiven or atoned; doing penance in prayer, 'confession' is sometimes described as the least understood of the seven sacraments; a reconciliation with God (a great source of grace); a right to anonymity in Roman Catholicism.

Conscientious objection – conscience-based refusal to supply a good or perform a service.

Covenant - a pledge, promise, settlement, or contract.

Decriminalisation of abortion - the removal of some or all of the criminal sanctions associated with abortion, so that instead of abortion being a crime for which there are some exceptions, abortion would be lawful except in exceptional circumstances. Decriminalisation does not mean deregulation. Limits can still be set, subject to professional and regulatory rather than criminal sanctions (BMA 2019).

Doctrine - a code of belief or body of teachings, taught positions, or instructions.

Duty to refer – a professional responsibility which governs care that practitioners cannot, or will not, provide.

Ensoulment - in religion and philosophy, the moment at which a human (or other fetal being) gains a soul, creating new life. 'Quickening' (first trimester fetal movements) is taken as an indication of the presence of a soul in different religions. This is variously established at

some point from conception to birth. For example, Aristotle estimated it to be 40 days from conception for men on 90 days for women.

Excommunication - also known as 'Disfellowshipping', an institutional act of a religious censure used to end or regulate the communion of a member of the Roman Catholic congregation. References to excommunication remind us of the power of the church and how its followers strive for compliance with its doctrine for fear about reprisal.

Gestational age – the length or duration of a pregnancy from the last menstrual period of on ultrasound calculation.

God's Mercy - God's power to overtake even the most arduous offence for a repentant heart, the phrase 'God's mercy' originates in Psalm (51:1), "Have mercy on me, oh God, according to your unfailing love".

Hail Mary (Ave Maria) - an angelical salutation in traditional Christian prayer addressing Mary, mother of Jesus, the phrase is attributed to Angel Gabriel's visitation to marry in the 'Annunciation' of pregnancy, the 'Immaculate Conception' Luke (1:28). Gillian refers to midwives who "Might go say ten 'Hail Mary' at the end of the day...but " (Gillian 439) after their participation in abortion.

Immaculate Conception - the belief that the Virgin Maria was free of original sin from the moment of her conception. Immaculate Conception is one of the four 'Marian dogmas' (beliefs about Maria) within the Catholic Church.

Incompatibility – a school of thought which holds it is contrary to the professional obligations of health care practitioners to refuse provision of any service within the scope of their professional competence.

Incomplete abortion - clinical presence of an open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus, or the expelled products are not consistent with the estimated duration of pregnancy. Common symptoms include heavy or prolonged vaginal bleeding and abdominal pain. Uncomplicated incomplete abortion can result after an induced or spontaneous abortion (i.e. miscarriage).

Induced abortion - intentional loss of an intrauterine pregnancy which is not intended to result in a live birth. This can be induced through pharmacological products (medical abortion) or through procedural techniques, such as vacuum aspiration (surgical abortion).

Liberal feminism - maintains that the process of gender roles is formed by socialisation, cognitive development and social learning. Removal of the obstacles to women's access to education, paid employment and political activity through established institutions enabling empowerment to participate equally in the public sphere is the main strategy for change. The emphasis is on legal change.

Midwife - a health professional who cares for mothers and newborns around childbirth, a specialization known as midwifery, having undergone a period of extensive education, training, and registration.

Miscarriage/Spontaneous abortion - spontaneous loss of a pregnancy before the fetus is 20 weeks. If the pregnancy has been expelled, the miscarriage is termed "complete" or "incomplete" depending on whether or not tissues are retained in the uterus. Miscarriage, also known in medical terms as a spontaneous abortion, is the death and expulsion of an embryo or fetus before it is able to survive independently. Miscarriage before 6 weeks of gestation is defined by European Society of Human Reproduction and Embryology (ESHRE) as biochemical loss. Once ultrasound or histological evidence shows that a pregnancy has existed, the used term is clinical miscarriage, which can be *early* before 12 weeks and *late* between 12-21 weeks. Fetal death after 20 weeks of gestation is also known as a stillbirth.

Missed/incomplete/threatened abortion - Clinical presence of an open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus, or the expelled products are not consistent with the estimated duration of pregnancy. Common symptoms include heavy or prolonged vaginal bleeding and abdominal pain. Uncomplicated incomplete abortion can result after an induced or spontaneous abortion (miscarriage).

Papal Infallibility - In Roman Catholic doctrine, a Pope cannot err when he speaks 'ex cathedra' (from his chair as supreme teacher) in defining a doctrine of Christian faith or morals.

Paternalism - the policy or practice on the part of people in authority of restricting the freedom and responsibilities of those subordinate to or otherwise dependent on them in their supposed interest.

Roman Catholic - related to the body of Christians following the Pope's authority, Roman Catholicism is the largest Christian Church with 1.3 billion baptised Catholics worldwide.

‘Catholic (from the Greek *katholikos,* meaning ‘universal) relates to a body of beliefs laid down by the church as the only interpretation of ‘revealed truth’.

Sacrament - in RC tradition, there are 7 sacraments: baptism; confirmation; Eucharist; penance and reconciliation; anointing of the sick; holy orders; matrimony. These are widely taken to represent signs given to us by Jesus Christ through which we share in God's life and in which believers may try to emulate those teachings. RC have a strong anti-abortion stance and thus an association with CO.

Sanctity - the state or quality of being holy, sacred, or saintly.

Service-user – anyone who uses or is affected by health and social care services from service providers. It can also imply a passive or restricted identity that ignores the aspects of a person.

Sin - in a religious context, sin is a transgression against divine law or a law of God. Each culture has its own interpretation of what it means to commit a sin. The doctrine of sin is central to Christianity, since its basic message is about redemption in Christ.

Synderesis - moral decision-making

Telemedicine – a mode of health service delivery where providers and clients, or providers and consultants, are separated by distance. That interaction may take place in real time (synchronously), by telephone or video link. But it may also take place asynchronously (store-and-forward), when a query is submitted and an answer provided later, by email or text/voice/audio message (WHO 2023)

The Concept of Forgiveness and Atonement of Sins - Generally, forgiveness is defined as an intentional decision to let go of resentment, hurt and rebuild trust. In Christian tradition forgiveness is achieved by true repentance through confession of sins) and thereby the liability of mortal sin (sin committed knowingly and freely). Francesca touches on this when as an abortion-provider she recounts how she was sprinkled with holy water (Francesca 253).

The Concept of Human Dignity - something a divine being gives to people in Catholic, social teaching, ‘human dignity’ is used specifically to support the church’s belief that every human life is sacred. Universal human rights are part of these beliefs.

The Innocent - free from grave sin or moral guilt, the term 'The Innocent' applied to Adam and Eve before the fall in the garden of Eden and is used in reference to the fetus. It is determined as a state of grace: a virginal value to aspire to but which in undertaking unprotected sex and then abortion may be unachievable without repentance of cardinal sin.

The Sanctity of Life - a value characterised in Judaeo-Christian doctrine as bodily human life which is seen as intrinsically good, and which believes that human life is sacred inviolable and a gift from God.

Trinity - first mentioned in Genesis as part of the creation story, where all three persons of the Trinity; Father, Son and Holy Spirit are present. Today it is mentioned during many Christian ceremonies and is a central belief of Christianity.

Unintended pregnancy – a pregnancy resulting from having sex without the intention of pregnancy, whether undertaken with contraception or not.

Unwanted pregnancy – a pregnancy in which the service-user decides to undergo induced abortion.

Veneration of the Virgin Mary - an honour given to Mary, the mother of Jesus, believed in Christian faith to be the Son of God, who co-operated in the work of the Saviour. A practice that dates back to the 2nd century, it involves various Marian devotions such as prayer, art, and music but is distinguished from the worship due only to God. Mary is a central figure of Christianity, venerated under various titles, and believed by some churches to be the Mother of God.

Appendix 16: Conferences/Presentations

Neil Stewart Associates, Northern Maternity and Midwifery Festival, 4th July 2023, Thesis Presentation/MATFLIX Podcast

International Confederation of Midwives 33rd Triennial Congress, Bali, Indonesia, 11-14th June 2023, Thesis Poster Presentation

Doctoral Academy Research Festival, LJMU, ‘Enhancing Doctoral Research on a Global Scale’, 11th May 2023, Thesis Poster Presentation

Neil Stewart Associates, London Maternity and Midwifery Festival, 7th May 2023, Thesis Poster Presentation

University of Dublin, IPA Group Ireland Symposium, 28th April 2023

University of Salford, IPA Group, ‘Focus on Research Decisions’ 15th March 2023

Doctoral Academy, Thesis-writing Bootcamp, 12-13th December and 11th-12th July 2022

Doctoral Academy, LJMU, Post-Graduate Research Festival 11th May 2022 Poster Presentation on Published works on DVA and Case-loading in Midwifery

Royal College of Midwives’ Annual Conference, 23rd– 25th March 2022 Poster Presentation (successful application but did not attend for medical reasons)

Dr Elena Gil-Rodriguez, Introduction to IPA; Situating IPA; Advanced Data Analysis for IPA (3-part workshop series), March 2022

Accommodating Conscience Research Network (AcORN) Conscientious Objection, Roundtable Symposium with Professor Valerie Fleming and Professor Mark Wicclair, November 2021

Professor Jonathan Smith, Introduction to IPA (two-part conference series) September 2021

Medical Safety Centre in Collaboration with Primaya Hospital, Indonesia, The Challenges of Perinatal Mortality: Early Detection and Prompt Response in Maternal and Neonatal Emergencies, 28th Aug 2021

London School of Economics, Global Access to Abortion facilitated by Dr Joe Strong, February 2021

Appendix 17: Publications

I also would like to highlight the following publications, which have been published before and during my PhD studies and have influenced or been influenced by the work contained within this thesis.

Richards, J. (2022) A Clearer View to Covid-19 Domestic Violence and Abuse – Gaining Insight by Using A Visionary Post-Feminist Lens, *Midirs Midwifery Digest;* 32(1) March 2022: 74-80 Available (online) from https://www.researchgate.net/publication/358928456

Richards, J. (2021) A Rethink on Conscientious Objection - From Midwives' Perspectives, *Academic Letters* Article 2840, August 2021 Available (online) from https://doi.org/10.20935/AL2840

Richards, J. (2021) A Less Than Typical Nursing Career – A New Look at Transferable Skills in Midwifery, *The Practising Midwife* Student Blog, July 2021, Available (online) https://www.all4maternity.com/a-less-than-typical-nursing-career

Richards, J. (2019) A Light at the End of the Tunnel in Hope for Recovery; *Stories of Healing from Eating Disorders* p. 35-38 ed. Catherine Brown and Christina Tinker USA: Brown-Tinker Books

Richards, J. (2018) A Critical Review of Case-loading in Theory and Practice *Practising Midwife* Mar 2018; 21(3): 20-24 Available (online) from https://doi.org/10.55975/UJTX1613

Richards, J. (2016) Learning to Aid Learning *Practising Midwife* January 2016; 19(1): 20-22 Available (online) from https://www.all4maternity.com

Richards, J. (1997) Too Choosy About Choice? *British Journal of Midwifery* March 1997; 5 (3): 163 -167 Available (online) from https://doi.org/10.12968/bjom.1997.5.3.163