

Background

The ethical principle of conscientious objection is of interest to many including ethicists, lawyers, health care professionals and the military. In the United Kingdom (UK) the only two laws which provide for conscientious objection allow health care professionals to object to the provision of abortion services through section 4 of the Abortion Act 1967 and through section 38 of the Human Fertilisation and Embryology Act 1990. This clearly separates abortion from other topical issues to which people are lodging objections such as officiating at same sex weddings, declining guesthouse accommodation to homosexual couples or refusing to bake wedding cakes for homosexual couples.

Section 4(1) of the 1967 Act, known as the “conscience clause”, provides that no one is under any duty to participate, contrary to his or her conscience, in any treatment authorised by the Act; although the exemption does not apply where treatment “is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman”.¹ When conscientious objection is applied to the health care settings providing legal abortion it often becomes the centre of acrimonious debate with practitioners and academics being polarised as to the rights and wrongs of both abortion itself and of health care professionals’ objections to participating in it.

Such issues came to the fore, when in 2012 the case of two Glasgow midwives, both practising Roman Catholics, exercising their legal right not to participate in the treatment of women undergoing abortions, was brought to the attention of the UK media. Based on their right to conscientious objection the midwives initially lodged internal grievance procedures in 2008. These were rejected so they instituted legal proceedings based on section 4(1) of the Abortion Act and Article 9 of the European Convention on Human Rights (ECHR). The question on which they sought clarity was, ‘Are the respondents [Greater Glasgow and Clyde Health Board (GGCHB)] entitled to require them to delegate, supervise and support staff in

the treatment of patients undergoing termination of pregnancy?’ The Court of Session in Edinburgh initially ruled against them both but the decision was overturned, following a successful appeal.

GGHB’s counter appeal was successful at the Supreme Court in London in November 2014. In this hearing, the five Supreme Court judges put aside the issue of the ECHR but found it necessary to clarify the meanings of “participation”[in abortion], concluding that it is only applicable to the provision of hands on care. What they did not examine was the period in which this care takes place, although some publications have acknowledged this difficulty.² The judges tested their definition against the arguments submitted initially by the midwives. The judges ruled that being present to assist and support if medical intervention were required was the only situation that should be fully covered by the conscience clause.³ GGCHB’s appeal was thus supported.

The case was followed with interest by many for ethical, religious or legal reasons and the present study was conceived as a result of the many unanswered ethical questions of relevance to practising midwives, in particular those of the Roman Catholic faith, who may experience similar tensions between their own consciences, what is required by their faith and their employers’ expectations. Of particular relevance is the binding nature of various legal systems on such practitioners: Scots Law (although the Abortion Act was enacted by the parliament in Westminster and covered Scotland, England and Wales), Canon law of the universal Roman Catholic Church⁴ and the Nursing and Midwifery Council’s (NMC) professional legislation. While the Code of Canon Law (CIC) 22 specifically states it is in harmony with the law of the region (or indeed that civil law takes preference where there may be a conflict, Canon 1398 penalises someone who carries out an abortion with an automatic excommunication; the most severe penalty the church can impose. The legislation of the NMC, whose primary role is to protect the public, includes a professional code⁵ which advises nurses and midwives to think “very carefully” before embarking on a course of conscientious objection.

Research questions and design

The theoretical underpinning of this project was Gadamer's⁶ hermeneutic out of which the method developed by Fleming, Robb & Gaidys⁷ involving a five stage approach has been used.

Stage one: defining research questions

- What are practising Roman Catholics' perspectives of potential conflicts between midwives' professional practice in Scotland with regard to involvement in abortions and their faith?
- How relevant is the "conscience clause" to midwifery practice today?
- What are participants' understandings of Canon 1398 in relation to midwifery practice?

Stage two: documenting the researchers' pre-understandings

Both of us are nurses and one a midwife, both coming from Christian backgrounds. We consider that the foetus is a human being from conception and that abortion represents the termination of a person's life, so neither of us has participated in abortion. Given the events that inspired this research we appreciate that we were very fortunate in that our beliefs did not cause us any difficulties when we worked in clinical practice, being for the most part, asked if we would be willing or not to participate and accepting our response without question. On further discussion we realised that if an emergency situation had arisen necessitating help we would have done what was required of us. We have noted our own beliefs in the spirit of reflexivity expected in the method adopted for this research. However, the development of the research questions and our dialogue with the data have also been influenced by the published literature, some of which is discussed in the next section.

Literature

The initial search was carried out from 2000-present on the databases: HEIN legal, Medline, CINAHL, Psycinfo, Academic Search Complete Web of Science using the search terms conscientious objection **and** abortion **and** nurse **or** midwife **or** midwives **or** physicians **or** doctors **or** medics (physicians hereafter). In total, 1082 records were retrieved and a further three were later added from reference lists from obtained articles. Following removal of duplicates, 293 abstracts were examined by the author who retrieved them. Next the focus was checked as to whether or not it was conscientious objection to abortion and only those that had this focus included. Finally, as the aim of this study concerns midwives we removed articles which exclusively concerned physicians.

Sulmsay⁸ makes the point that despite many debates on conscience, insufficient attention has been paid to understanding what conscience actually is and its potential importance.

The philosophical concept of conscience, however, derives from the ancient Greeks with Aristotle stating that a mature conscience allows persons who know what they are doing to act virtuously.⁹ In the New Testament, as well as in some non-Christian writings of the same period,¹⁰ the concept of conscience is articulated. In a frequently cited passage, Paul remarks that the Gentiles “can point to the substance of the Law engraved on their hearts – they can call a witness, that is, their own conscience – they have accusation and defence, that is, their own inner mental dialogue”.¹¹ It was, however, Thomas Aquinas who developed the Aristotelian notion of conscience more fully concluding that conscience is not a power but an act as, by its very nature, it implies the relation of knowledge to individual cases.¹² Such was the basis for a considerable body of philosophers’ works over successive centuries.

In the 20th century and beyond, the “act” in Aquinas’ conceptualisation, has commonly been found in changing health care settings, especially those concerned with reproductive technologies. In making his claim, therefore, Sulmsay appears to have ignored the large body of philosophy as well as the seminal work of Wicclair¹³ who provided a comprehensive link between conscience and integrity in medicine. Wicclair concludes that *carte blanche* rights of conscientious objection should not be given but rather respect for the moral

integrity of the physician even in practices endorsed by the medical profession is the best way forward. Wicclair's position was supported by Antommaria¹⁴ who reasoned that conscience needed to be understood as synonymous with the maintenance of personal integrity. Claims of conscientious objection thus derive from the importance of the value of integrity underpinning them.

Weinstock¹⁵ comments that if a health professional's right to conscientious objection is respected, "respect [is afforded to] the moral agency of those who hold reasonable dissenting views". Likewise, Curlin et al¹⁶ reflect that "acting conscientiously is the heart of the ethical life" and if medical practitioners give this up they no longer have the capacity to make or act in accordance with moral judgments. How to judge that something is truly based on a strong conviction of conscience is beyond the scope of this paper although various authors have proposed criteria which could be adopted.^{17,18}

Such debates among philosophers and ethicists may initially appear to be well removed from the realities of present day practice. However, some writers bring this closer reflecting on the "rampant spread" of conscientious objection in health care settings¹⁹ while others contest the rights of health care professionals to allow their private values to interfere with their work.²⁰ Contrary to the views of Zampas and other authors,²¹ Neal et al²² suggest that the apparent expansion of conscientious objection claims is based on poorly defined or even contradictory professional guidelines and there is a need for sound research establishing working definitions.

Addressing this, the International Federation of Obstetricians and Gynaecologists (FIGO) published criteria²³ for conscientious objection as providing notice, referring patients timeously and providing emergency care. While brief, the standards have been the subject of many commentaries and explanations²⁴ yet there is still polarisation of the rights and responsibilities of health care providers in relation to the women's expectations. Heino et al for example state that "European countries should critically assess the laws governing

conscientious objection and its effects on women's legal rights".²⁵ Conversely Pellegrino²⁶ asserts that a health professional's conscience or religious values should never be placed in a secondary position to the health service's requirements. A "White Paper"²⁷ drawing on international, multidisciplinary literature attempts to sum up the issue and develop a road map for the future. The authors give clear acknowledgement to the lack of well carried out empirical research on the topic but conclude from reviewing the available evidence that there is a growing trend towards refusal to provide certain reproductive health services especially abortion. Acknowledging the difficulty of the situation they recommend that a standard definition of conscientious objection be developed together with accompanying obligations.

A paucity of literature exists concerning the change from surgical to medical abortions. Surgical abortions were carried out exclusively by doctors assisted by nurses in an operating theatre. Both in the theatre and pre and post operatively those who expressed a conscientious objection to the procedure were not expected to participate. With medical abortions, the prescription is written by a medical practitioner, but the drug is administered by a nurse, midwife or the woman herself. The woman is cared for throughout the subsequent labour by midwives. Only one article²⁸ acknowledges this, commenting that many more health professionals are now involved over a much longer period of time. The only research based article located specifically concerning midwives reports a qualitative study carried out in Switzerland.²⁹ Although this study predates some of the above cited literature, it appears to be lacking in rigour due to its failure to provide raw data in the form of rich quotes. It was strongly criticised by Newell³⁰ who commenting in line with the journal's requirements, pointed out that "we do not have much of an insight into the moral reasoning of these midwives, especially in terms of their wider professional and social dialectic".

Stage three: dialogue with participants

Participants were selected by purposeful sampling seeking those who could address the aims of the study. Contact was initiated through parish priests in southern Scotland who agreed to act as gatekeepers. Requirements were to be a practising Roman Catholic familiar with the subject of conscientious objection and either a health professional, a lawyer (civil, Canon or both) or a priest. Eight participants, two midwives, two lawyers, two canon lawyers and two priests were recruited, yielding a rich amount of data. Primary data were collected through unstructured but focused individual interviews which were audio recorded and transcribed verbatim.

Ethical considerations

The major ethical issues in this study were those of confidentiality, autonomy and informed consent. Prospective participants who had shared their details with the gatekeeper were sent copies of the relevant legislation together with an information sheet about the study and asked to read this before deciding whether to participate. A telephone call from a researcher clarified any points and sought permission to participate. Those who agreed signed a consent form. All legal requirements were addressed regarding data collection and storage. Approval was given by the ethics committee of the university with which one of the researchers was associated [MI2015BD2].

Stage four: dialogue with the data

Data were analysed according to the Gadamerian aim of fusion of horizons which comes about through the development of our understanding following interaction with the literature, the participants and the data. It is important to note that understanding the other can never be achieved totally in any study, as it is constantly evolving.³¹ This development, known as the hermeneutic circle showed how during the course of the research our initial views were altered and shaped by our dialogue with the participants. The research process therefore facilitated this “fusion of horizons” which is reflected by our moving from the whole to the parts to reach the new fused horizon. Here the whole included all data and the parts meaning units and themes from each participant. In order to enter the hermeneutic circle and as we both supported the principle of conscientious objection, we had identified

as many of our pre-understandings of the subject of abortion and the care of women undergoing this procedure as possible. We did this through conversations prior to undertaking the study and our developing understanding was reviewed at points during the study.

Initially we developed five themes but as we moved within the hermeneutic circle, it became clear that some could be subsumed in others and they were too simplistic. Finally we identified three key themes that provide an understanding of the situation in which midwives find themselves: competing legal systems, competing views of conscience and limits of participation. These themes are presented and discussed with direct quotes from participants and with reference to published literature to demonstrate the trustworthiness of the analysis.

Competing legal systems

While, as shown in the introduction, the law of the country has legislated for the provision of abortion in certain conditions, the law of the Catholic Church sees it as a crime.² This discrepancy is due to the Church viewing the moment of conception as the commencement of personhood but state law not sharing this view. NMC law demands that nurses and midwives focus on the needs of the patient or client, in this case the pregnant woman. Both midwives participating in this study were clear as to their own beliefs of abortion, one describing her perspective as:

I don't think it's harsh but I just wonder whether any of them understand what they're doing. I mean if you kill someone who is half an inch long or whether you kill somebody who is six feet long it is the same crime, but what is the background to that person? Has she ever had any religious education, has she ever had any teaching?

[midwife 1]

This midwife identifies the foetus as a person and abortion as killing a person. If one accepts this view, it makes it impossible for that person to participate. Whilst the a conscience clause allows a midwife to refuse to participate, it does not always necessarily function in current clinical practice as it did in the past,

‘..there was a conscience clause which was respected and if you said “I’m a practising Christian or a practising Catholic” that was respected. But now... you can see that if you start saying these things you are a nuisance.’ [midwife 1]

One of the Canon lawyers, however, in the study emphasised the church’s view stating:

It comes back to the question is a woman in charge of her body to the extent to which she can decide what happens to this other life? I think that is what you have to get across to young Catholic midwives, is the sanctity that that baby from conception is another human being.[canon lawyer 2]

The legal conflicts were immediately visible, just as the legal case of the two Glasgow midwives brought this issue to the attention of the public as canon lawyer 1 indicated:

‘it is not just a Catholic thing, there’s been many others standing up in support of them (the midwives at the centre of the case), whether they are religious or not. They’re 100% behind them.’

Whilst this study is focused on Catholic midwives, this statement highlights that others may have the same perspective. This could mean that midwives conscientiously objecting to abortion will have a similar difficulty when trying to follow their conscience. The suggestion that a midwife may be seen not to be carrying out all duties prescribed in her job description by invoking the conscience clause is relevant to this theme as well. Lawyer 2 stated:

‘Because legally there is no way round it, there just is no way. If you’re not doing the job you’ve been employed to do then that’s not the employer’s problem, that’s your problem.’

This view is reinforced by lawyer1

'...It doesn't matter whether something is legally right or wrong if it's legally valid it's what matters.'

Despite the conscience clause, this would seem to be the key employment issue that puts midwives in such a difficult place because it directly conflicts with CIC where abortion is equated with murder. It was clear from the Glasgow midwives' case that some midwives find it challenging to use this as a way to avoid dealing with any aspect of abortion without difficulty in the workplace.

It can therefore be seen that there are apparently two conflicting or competing secondary legal systems which have arisen from differing viewpoints: the sanctity of life and the rights of women to make decisions relating to their own health and well-being. The former is espoused in the CIC, binding upon all Catholics and clarified in the Catechism of the Catholic Church: 2270³² which classifies abortion as "intentional homicide" reiterating that "human life must be respected and protected absolutely from the moment of conception". The second system is found in the NMC's legislation binding upon all midwives in the UK, which states that midwives with a conscientious objection must inform their colleagues, managers and the person requiring care and arrange a suitable colleague to take over.

If the situation had remained as it was when the two authors were in clinical practice the clash between these two legal systems may never have been highlighted. In addition, the case of the Glasgow midwives has raised awareness of what actually happens during abortion and has brought the issue of conscience into the public forum. These issues may impact on the public view as suggested by priest 1 who stated

Because what about the prevailing mind sets I suppose that abortion is something that is about women's rights and it's allowed...this prevailing right is being applied, if you like, to abortion in this case. But what if this mind set changes?

The view that all things change is reinforced by lawyer2,

...I mean I know for myself that the job I do now is probably not a job that is going to be there in the next 20 years so I will have moved on. But people from the older generation wouldn't necessarily appreciate that, particularly in the medical field that's tough luck. Because things do move and you're going to have to move with the times. He suggests that this may be 'tough luck' presumably if it is a change that an individual does not like. If the mind set changes as suggested by the priest, abortion could again be seen by society as unacceptable. However, many would not see this as a positive change, in particular those for whom the rights of the woman should take precedence in all situations even when a second life is involved.^{17,23}

Currently, midwives have to make decisions while trying to reconcile the three non-complementary legal systems. This may have been exactly the type of scenario that the legislators were envisaging in drafting the conscience clause and leads to the second theme in which we consider how participants' consciences shape their understandings of participation in abortion and is the basis on which they make decisions taking account of the consequences of each of the legal systems.

Competing views of conscience

There was a strong indication in the data the midwives believed they should not be taking part in abortion, the following quotes being typical of their comments, 'Well my belief is they shouldn't be taking part in any kind of termination. They shouldn't be party to it.' [midwife 1]

The suggestion from the above statement is that not only should midwives not take part in any type of abortion they should not be involved in any aspect of the procedure.

Midwife 2 suggested: 'you have to remove yourself from that position.'

This may lead to difficulties for the practitioner with midwife 2 identifying that the expression of conscience can be seen as being judgemental, 'I mean immediately you get

like 'why are you judging the woman? Why are you doing..?' And they don't see it, they don't see that you're not saying that at all.'

It is easy to see how this view could arise in a busy clinical situation as there is unlikely to be time to explain that while the midwife's conscience does not allow her to participate in abortion she is not judging the woman. An additional problem is highlighted by our reflexivity; neither of us made judgements on such women but recognised that the individual required care and that our objection meant that someone else would have to give it. It could be suggested that a judgement is being inadvertently made on the staff that would have to provide this care. It could be that the prime concern for staff members is the situation in which the woman has found herself and the belief that she has the right to make decisions regarding her own body. The woman's need for care and support during the procedure is the priority and meets the NMC (2015) demands in the Code of Professional Conduct.

Lawyer 1 suggested that the Catholic Church may be wrong in preventing midwives from giving care to a woman undergoing abortion,

'Yes, but if it was my job to care for them, is the Catholic Church saying that I shouldn't care for and love that person because they're in a very vulnerable position? I think that's wrong.'

The current Pope has recently made a statement indicating that the family is there to protect and nurture children including those who are not yet born.³³ This does not negate the Christian principle of caring for others and does not address the question of what level of care a midwife can give to a woman undergoing abortion.⁹

The Royal College of Midwives' (RCM) guidance to its members³⁴ states that a midwife may have to weigh up her own position in relation to the woman's interests and hand over her care to another midwife if conflicts arise due to her conscience. They do not suggest how this can be achieved in a busy ward. However, women are entitled to the best possible care, provided by midwives who can offer genuine empathy and not feeling repelled by the

situation and every effort should be made to provide such care. Midwives, too, as “mid-level health care providers”³⁵ are almost always employees in a field dominated by medicine. This means that even if the imperative for a doctor with a conscientious objection to abortion was to refer promptly to another practitioner, midwives normally do not have such flexibility to do this. Likewise, some commentators on “conscientious objection” suggest that, by referring, the practice of abortion is being condoned.³⁶ This may seem rather unhelpful as if a healthcare provider felt unable to refer the woman to a colleague she may not get the care she requires. Equally as unhelpful is the view expressed by midwife 1:

‘You know, this [abortion] is not the role of the midwife’

This does not address the fundamental issue of care for the women undergoing abortion as nurses would be required to provide the necessary care if they were transferred to the gynaecology area. The same principles would apply raising the same question regarding the limits to the provision of care: the third theme.

Limits to participation

As with their struggles to reconcile the three legal systems, participants were not agreed in their thinking as to what their participation in abortion meant though were agreed that abortion was terminating a human life. However, the women being admitted for the legal procedure of abortion require care as is clear from the NMC’s mission statement which demands that midwives be supportive and non-judgemental in their care. This is recognised by lawyer 1,

You’re [a woman admitted for termination of pregnancy] in a very vulnerable position and you’ve come to a decision to come to and what they need is someone who can be fully supportive of their position, their health and well-being.

The imperative to provide care to others is possibly one of the issues making it difficult for a midwife to decide what constitutes participation in abortion. It has already been discussed

that participants in this study considered midwives should have no part in it, but what constitutes participation is the difficulty. The confusion demonstrated by midwife 2 highlights this:

‘Well, I would only cite the venflon [a cannula inserted into a vein to allow administration of medication], I would only do it, well I was in kind of two minds about it but I was the only one there who could and we didn’t have a junior doctor at that time. And she had to get these drugs and the ward was so chaotic. So I did go in and I didn’t ask anything about. And I actually helped to make the drugs up because I was the only other person who could sign the more junior midwife to do that. So I suppose in a way I did participate, but...’

A busy labour ward put this midwife in the position where she participated in the procedure to a greater extent than her conscience allowed. This discomfort led her to a discussion with her father and a decision about her career,

‘Well I phoned my dad about it. I didn’t know about Canon law...I knew it was a sin but when I read that I was a wee bit frightened. But I think that this all came at the right time for me because I’m going to have to make a choice about my career...Maybe at [another hospital] I can be the kind of midwife I want to be.’ [midwife 2]

The difficulty in trying to stay true to her conscience but support a more junior midwife in meeting the needs of a woman requiring care caused this midwife so much stress that she is seeking different employment. Although her actions supported both the woman and the junior midwife and met the demands of the NMC she could not reconcile these actions with the demands of her faith. Her participation enabled another midwife who was not competent to carry out these aspects of care to administer the drugs.

The RCM made the statement in the Supreme Court that it believed that abortion care only included administration of the abortifacient drugs and subsequent care was termed “ordinary and pastoral nursing care”. While this is consistent with their previous

statements²⁹ there is no clarification of the phrase “ordinary nursing and pastoral care”.

Unlike the NMC, the RCM has no legislative power over its members but its stance raises interesting questions. For example, the insertion of the cannula and making up of drugs are key aspects of the administration process in the protocols in the hospital which employed midwife 2. Participants in this study thus saw these tasks as part of the abortion process. Such issues highlight not only, the dilemma experienced by midwife 2 but the much wider concern as to what the limits of participation are.

The fact that abortions are carried out regularly in the labour ward adds to the stress of a midwife who does not wish to participate in this procedure as can be seen in the next quote,

‘I’ve been trying to say to people about the foetal medicine thing [a dedicated room where abortions take place] because that’s constantly playing on my mind. Every day there’s someone. And it’s only going to be a matter of time before somebody says to me “will you do that room?” [midwife 2]

This midwife knows that she would then be in the difficult position of having to identify that ‘doing that room’ would be against her conscience. Even if this were accepted she could be in the position of the midwife who felt obliged to assist a more junior midwife to give the required care.

A landmark legal case in 1981³⁷ which requested clarity on the legality of nurses taking part in mid-trimester abortions carried out by medical means appears to have provided an answer as the primary question was what actually constituted carrying out the abortion.

Lord Keith’s words summed up the general judgement:

‘Termination of pregnancy’ is an expression commonly used, perhaps rather more by medical people than by laymen, to describe in neutral and unemotive terms the bringing about of an abortion. So used, it is capable of covering the whole process designed to lead to that result, and in my view it does so in the present context. Other provisions of the Act make it clear that termination of pregnancy is envisaged as being

a process of treatment.

Thus, it was clearly established that abortion in the UK is legally considered to be a process rather than a single act or combination of acts.

Such a scenario paints an opposing picture to the RCM's stance that conscientious objection should only apply to the administering of the medication. If the physiological hypothesis is accepted then unless medical intervention is required it would normally be the attending midwife who completes the abortion.

Green³⁸ however, disagrees discussing the potential extent of those involved in procuring abortion seeing this more in line with how Lord Keith defined it. Technically, once labour starts, an abortion could proceed with the woman unaccompanied by any health professionals. This is the situation, however, that the Abortion Act sought to overcome and against which organisations such as the WHO are now campaigning as in the past illegal abortions led to many maternal deaths and a similar situation would be unacceptable nowadays.

The limits to participation in abortion although unclear in this study is an indication that practice is reflective of the debates going on in academic and legal circles and which are yet to be resolved.

Lawyer 2 suggested that midwives who refuse to participate in the care of women undergoing abortion should not stay in this employment,

'They're refusing to do (midwives who refuse to participate in abortion) what their job requires them to do. They have to remove themselves from that kind of work.'

Likewise priest 2 suggested that things were getting to the stage that 'Catholics need not apply, at least those whose religion means anything'

Taking such approaches imposes limits on where a midwife with a conscientious objection to abortion could work in order not to be seen as someone who refuses to carry out all components of the job for which she has been employed and indeed whether practising

Catholics could even work as midwives. It is an issue that needs to be taken into consideration by people seeking to enter the profession as it does offer employers a potential way around being bound by the conscience clause except in a minority of situations.

Fusion of horizons

This study has yielded more questions than answers regarding potential ethical conflicts between midwives' professional practice involving women undergoing abortion in Scotland and their faith. Such conflicts were also the major issue in the case in the two Glasgow midwives' case, where in the first hearing it was stated that most women are in labour ward to achieve a 'joyful outcome' i.e. the birth of their healthy child.³⁹ This was supported in the Supreme Court where it was noted that abortions form a 'tiny proportion' of all cases. However, it has been shown that section 4(i) of the Abortion Act is highly relevant to midwifery practice today as medical terminations take place almost daily in some labour wards.

Staffing levels make it difficult for those with a conscientious objection to abortion to work in a labour ward and if the procedure were transferred to another area such as a gynaecology ward the problem would simply transfer with it. This is in contrast to the time when we were in clinical practice. We identified in our discussions that we make no judgement on the women coming for abortion and feel that these women require skilled care to ensure their physical and psychological safety. On reflection, this realisation gives us a degree of difficulty as whilst we would not participate in their care, we knew that they required care and that somebody else would have to give it. We wonder what would have happened, or what would happen now, if no-one else were available.

Conclusions and recommendations

The UK law relating to abortion is based on the needs for women to have an abortion service that is hygienic and safe. It is also essential that no change be made to the law that would

result in women in desperate situations seeking abortions from unqualified practitioners in dangerous situations as was the case with 'backstreet abortions' in the past.

Both the UK law and Canon law, however, were promulgated many years ago when abortion was primarily a surgical technique and midwives were scarcely exposed to it. However, there have been many changes in clinical practice and as one of our participants noted 'no law is forever'. It is thus timely that the law took such changes into account. In many other countries the abortion law allows women the free choice of abortion up to a certain stage in the pregnancy. As there are currently discussions underway in Scotland and the rest of the UK about this, they must also take into account that if such a law is passed, it must also include the choice of midwives and other health professionals to opt out and provide clear guidelines for the women concerned as to how to ensure their wishes are honoured without preventing the health professionals from exercising their own human rights. Clarification of Canon 1398 in relation to what is and is not participation in the procurement of abortion would also be of benefit to midwives with a conscientious objection.

Finally, as seen in both the literature and from our participants, the time has come to provide clear guidelines developed by a multi professional and consumer group relating to the scope of and the limits to both participation in abortion and to conscientious objection.

References

¹ *Abortion Act 1967* London: Her Majesty's Stationary Office.

-
- ² Fletcher R. Conscientious objection, harm reduction and abortion care. In Donnelly M & Murray C. 2016 *Ethical and legal debates in Irish healthcare*. Manchester: Manchester University Press.
- ³ Greater Glasgow and Clyde Health Board (Appellant) v Doogan and another (Respondents) (Scotland). *Case UKSC 2013/0124. UK Supreme Court, London, 5 November, 2014.*
https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0124_Judgment.pdf
 (Accessed 23 March 2017).
- ⁴ *Code of Canon Law* Latin English version. Washington: Canon Law Society of America 1983.
- ⁵ Nursing and Midwifery Council *Code of practice* 2015
<http://www.nmc.org.uk/standards/code/> (accessed 18 January 2017)
- ⁶ Gadamer HG *Wahrheit und Methode*. Tübingen: JB Mohr 1960/1990.
- ⁷ Fleming V, Robb Y and Gaidys U. Hermeneutic research in nursing: developing a Gadamerian research method. *Nursing Inquiry* 2003; 10: 113 – 120.
- ⁸ Sulmasy D. What is conscience and why is respect for it so important? *Theoretical Medicine and Bioethics* 2008; 29: 135-149.
- ⁹ Caston V. Aristotle on conscientiousness. *Mind* 2004; 111: 751 -815.
- ¹⁰ Rolleston T. *The teachings of Epictetus*. London: Scott, 1880.
- ¹¹ *The Holy Bible* 1974. Jerusalem edition. London: Darton, Longman and Todd.
- ¹² St Thomas Aquinas *Summa Theologica first part. Question 79 article 13*
<http://www.newadvent.org/summa/1079.htm#article13> (c. 1265). Accessed 18 January 2017.
- ¹³ Wicclair M. Conscientious objection in medicine. *Bioethics*, 2000; 14: 205-227.
- ¹⁴ Antommara A. Conscientious objection in clinical practice: Notice, informed consent, referral, and emergency treatment. *Ave Maria Law Review*, 2010; 9: 81-99.
- ¹⁵ Weinstock D. Conscientious refusal and health professionals: Does religion make a difference? *Bioethics*, 2014; 28: 8-15.
- ¹⁶ Curlin F, Lawrence R, Chin M and Lantos J. Religion, conscience, and controversial clinical practices. *New England Journal of Medicine*, 2007; 356:593-600.
- ¹⁷ Myers C, Wood R. An obligation to provide abortion services. What happens when physicians refuse? *Journal of Medical Ethics*, 1996, 22, 115-120.
- ¹⁸ Neal M.. In good conscience: conscience-based exemptions and proper medical treatment. *Paper presented at a seminar in the Law School University of Sheffield, January 2015.*

-
- ¹⁹ Zampas C. Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings. *International Journal of Gynecology and Obstetrics*, 2013; 123: 563-565.
- ²⁰ Baker R. Conscience and the unconscionable. *Bioethics*, 2009; 23: II-III.
- ²¹ Myers C and Wood R. An obligation to provide abortion services. What happens when physicians refuse? *Journal of Medical Ethics*, 1996; 22: 115-120.
- ²² Neal M. In good conscience: conscience-based exemptions and proper medical treatment. *Paper presented at a seminar in the Law School University of Sheffield, January 2015.*
- ²³ International Federation of Gynaecology and Obstetrics (2006). *Conscientious objection: position statement.*
<http://www.figo.org/sites/default/files/uploads/OurWork/2006%20Resolution%20on%20Conscientious%20Objection.pdf> 2006. Accessed 18 January 2017.
- ²⁴ Cook R, Olaya M and Dickens B. Healthcare responsibilities and conscientious objection. *International Journal of Gynecology and Obstetrics*, 2009; 104: 249-252.
- ²⁵ Heino A, Gissler M, Apter D and Fiala C. Conscientious objection and induced abortion in Europe. *The European Journal of Contraception and Reproductive Health Care*, 2013; 18: 213-233.
- ²⁶ Pellegrino E. The physician's conscience, conscience clause and religious belief; a Catholic perspective. *Fordham Urban Law Journal*, 2002; 30 (1): 220-244.
- ²⁷ Chavkin W, Leitman L and Polin K. Conscientious objection and refusal to provide reproductive healthcare. *International Journal of Gynecology and Obstetrics*, 2013; 123: 541-556.
- ²⁸ Kane R. Conscientious objection to termination and pregnancy: the competing rights of patients and nurses. *Journal of Nursing Management*, 2009; 17: 907-912.
- ²⁹ Cignacco E. Between professional duty and ethical confusion: midwives and selective termination of pregnancy. *Nursing Ethics*, 2002; 9(2): 179-191.
- ³⁰ Newell C. Response to Cignacco. *Nursing Ethics*, 2002; 9(2): 191-193.
- ³¹ Bishop E, Shepherd M. Ethical reflections: examining reflexivity through the narrative paradigm. *Qualitative Health Research*, 2011; 21, 1283-1294.
- ³² The Holy See. *Catechism of the Catholic Church* (popular and definitive edition). London: Burns & Oates 2000.

³³ Francis P. *Amoris Laetitia* paragraph 83

https://w2.vatican.va/content/dam/francesco/pdf/apost_exhortations/documents/papa-francesco_esortazione-ap_20160319_amoris-laetitia_en.pdf accessed 18 January 2017.

³⁴ Royal College of Midwives. *Position Paper No.17, Conscientious Objection*. London: RCM. April, 1997.

³⁵ Sedgh G, Bankole A, Singh and Eilers M. Legal abortion levels and trends by woman's age at termination. *International Perspectives on Sexual & Reproductive Health*, 2012;. 38(3):143-53.

³⁶ Cavanaugh T. Professional conscientious objection in medicine with attention to referral. *Ave Maria Law Review*, 2011; 9(1): 189-206

³⁷ *Royal College of Nursing vs Department of Health and Social Security (DHSS)* 1981. Case number HL/PO/JU/18/241. Available: <http://www.bailii.org/uk/cases/UKHL/1980/10.html> accessed 18 January 2017.

³⁸ Green T. Commentary on Canon 1329. In J Beal, J Corriden and T Green (eds.) *New commentary on the Code of Canon Law* pp. 1547-1548. New Jersey: Paulist Press 2000

³⁹ *Doogan, M. & Wood, C. vs Greater Glasgow and Clyde Health Board* 2012. Case P876/11. Outer House of Court of Session Edinburgh, 29 February. Available: <https://www.scotcourts.gov.uk/search-judgments/judgment?id=6fb28aa6-8980-69d2-b500-ff0000d74aa7> accessed 18 January 2017.