UK Service Users' Experiences of and Views on Healthcare Practitioners' Right to Conscientiously Object to Abortion

Becky Self

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

SEPTEMBER 2023

Declaration

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.

Abstract

The fourth section of the 1967 Abortion Act states that individuals (including healthcare practitioners) do not have to participate in an abortion if they have a conscientious objection to this procedure. A conscientious objection is a refusal to participate on the grounds of conscience. It may be informed by religious, moral, philosophical, ethical, or personal beliefs. Recently, Northern Ireland introduced The Abortion (Northern Ireland) Regulations 2022, part 7 of which mirrors the 1967 Abortion Act’s conscientious objection clause. Currently, no research has been conducted on service users’ views on conscientious objection and there has been very little investigation into the impact of conscientious objection on service users in the UK. This perspective is imperative in understanding the real-world consequences and impact of conscientious objection and should be considered when creating policy and guidelines. I undertook this research from a liberal feminist stance. I provided a platform for women and those who can become pregnant to share their experiences and views at a time when their voices are largely excluded from the great tradition of Western political philosophy and law-making processes. I interviewed 25 UK service users from urban and rural areas using a hybrid approach. I combined the principles of narrative and semi-structured interviews. I analysed the data using found poetry and a reflexive liberal feminist thematic analysis. My findings indicate that conscientious objection could work in practice. However, it is currently failing some individuals, as healthcare practitioners do not always inform service users of their objection, or that they are able to access an abortion, and how to access one (indirect referral). Participants did not experience burdens such as long waiting times and were still able to access legal abortion. However, they did experience negative emotional effects, as they were often left feeling scared, angry, and hopeless when they were not referred. Moreover, participants’ views on conscientious objection in the UK varied considerably. The majority supported the most common approach within the literature and in practice, whereby healthcare practitioners can object so long as they refer and inform the service user. However, the opinion that healthcare practitioners should not be allowed to object or should be able to object without referring the service user to another healthcare professional and informing them of their right to an abortion was also evident. The

importance of my research lies in elucidating the impact that conscientious objection is having on service users in the UK, and in highlighting service users' views on conscientious objection.

Presentations

Self, B (2022) ‘UK Service Users' Experiences and Opinions of Health Care Practitioners' Right to Conscientiously Object to Abortion’, LJMU Research and Knowledge Exchange Conference, Navigating Pandemic Times. Liverpool John Moores University (Poster Presentation)

Self, B (2022) ‘UK Service Users' Experiences and Opinions of Health Care Practitioners' Right to Conscientiously Object to Abortion’, LJMU Research and Knowledge Exchange Conference, Navigating Pandemic Times. Liverpool John Moores University (Oral Presentation)

Self, B (2022) ‘UK Service Users' Experiences and Opinions of Health Care Practitioners' Right to Conscientiously Object to Abortion’, Liverpool John Moores Postgraduate Research Festival. Liverpool John Moores University. (Poster Presentation)

Self, B (2022) Three-minute thesis: The missing voice in the conscientious objection debate. Liverpool John Moores Postgraduate Research Festival. Liverpool John Moores University (Oral Presentation)

Self, B (2022) Three-minute thesis: The missing voice in the conscientious objection debate. Faculty heat. Liverpool John Moores University. (Oral Presentation) (Faculty winner)

Publications

Self, B. (2021). Conducting Interviews During the COVID-19 Pandemic and Beyond. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *22*(3). https://doi.org/10.17169/fqs-22.3.3741

Self, B., Maxwell, C. & Fleming, V. (2023). The missing voices in the conscientious objection debate: British service users' experiences of conscientious objection to abortion. *BMC Med Ethics, 24*(65). https://doi.org/10.1186/s12910-023-00934-9

Acknowledgements

Firstly, I owe a massive thank you to my participants. My programme of research would not exist without them. Thank you for sharing your experiences, views, and time with me.

Thank you to my supervisors Professor Valerie Fleming and Dr Clare Maxwell. I am so grateful for your guidance and support. Thank you for having confidence in me and allowing me to develop as a researcher, whilst challenging me to think critically about my own work and reflect on the work of others. It has been a privilege to work with and learn from you.

I would also like to thank my support system of family and friends. Thank you to my mum Paula Newman, for being the best role model, to Steve Bullimore and Paul Newman my father figures, and my sister Hayley Knight. In particular, I would like to thank my PhD buddy and close friend Jacquie Richards for our daily calls and discussions and all-round support; the PhD journey would have been a struggle without you. I would also like to thank my partner Stuart Doughty for always believing in me and supporting me in every way.

Lastly, a special thank you to my springer spaniel Loki, who is by my side every day, forcing me to take a break and reset in the outdoors.

Dedication

I would like to dedicate this programme of research to my nanny Mary Lake who sadly passed away while I was undertaking this research. If she were here today she would be encouraging me with one liners, even if she did not always get them quite right.

Contents

List of Figures

List of Tables

Abbreviations

BMA	British Medical Association
BPAS	British Pregnancy Advisory Service
CO	Conscientious Objection
DDE	Doctrine of Double Effect
GMC	General Medical Council
GP	General Practitioner
HCP	Healthcare Professional
LGBTQ+	Lesbian, Gay, Bi, Transgender, Queer, and Others
MSI	MSI Reproductive Choices
NHS	National Health Service
NI	Northern Ireland
NIHRC	Northern Ireland Human Rights Commission
NMC	Nursing and Midwifery Council
POC	People of Colour
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
SU	Service User
UK	United Kingdom
US	United States
VoIP	Voice over Internet Protocol
WHO	World Health Organization

Chapter One: Conscientious Objection to Abortion in the United Kingdom and the Missing Voices in the Conscientious Objection Debate

Introduction

I undertook this programme of research to explore United Kingdom (UK) service users' experiences and views on conscientious objection to abortion. My objective was to gain an understanding of how service users' abortion journeys progress in practice, the impact that conscientious objection has on service user's abortion journeys, and service users' views on conscientious objection. In the following chapter, I provide an introduction to, abortion in the UK, conscientious objection to abortion, and how conscientious objection is presented in policy and guidelines for midwives, nurses, and doctors. I then outline the research questions and the rationale underpinning my research. I conclude the chapter with an overview of my programme of research and the contribution it makes to both literature and practice.

Abortion in the UK

England and Wales

Abortion conducted by healthcare professionals was legalised on certain grounds in England and Wales in 1967 with the introduction of the Abortion Act (Abortion Act, 1967). The Act was introduced by Sir David Steel and was supported by the government under a free vote. The Act was passed in a political context of concern over inequality regarding abortion access. Wealthy individuals could pay for safe, private abortions while those of moderate means had no choice but to access less safe abortion services at the risk of criminalisation (Calkin & Berny, 2021). Section one of the Act reads:

"Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith-

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped." (Abortion Act, 1967, p. 1).

Abortion in England and Wales is not available on demand, as one of the circumstances above must be met for it to be legal. Nevertheless, the Abortion Act is generally interpreted liberally by English and Welsh doctors, as the majority of abortions in England and Wales (98% in 2021) are performed under the first ground of the Abortion Act (the pregnancy is under 24 weeks and if the pregnant person continued the pregnancy, it would pose a greater risk to their physical or mental health than if they had an abortion) (Department of Health and Social Care, 2023). This broad interpretation means abortion is available on request, although this is not enshrined in law.

In addition, a further 1.6% of abortions in 2021 in England and Wales were performed because continuation of the pregnancy would have resulted in the child suffering from physical or mental abnormalities (Department of Health and Social Care, 2023). Moreover, the majority of abortions are performed under 10 weeks' gestation (89% in 2021), a figure that has continued to increase since 2011 (Department of Health and Social Care, 2023). The increase in early gestation abortions is partly due to advances in abortion technology and methods since the introduction of the Abortion Act. Abortions which are performed over the 24 week limit (in the case of severe foetal abnormality or in cases of danger to the physical health or life of the pregnant person) are rare and accounted for

0.1% of abortions in England and Wales in 2021 (Department of Health and Social Care, 2023).

Northern Ireland

In 2019, abortion was decriminalised in Northern Ireland (NI). Prior to this, NI was governed by the Offences Against the Person Act (1861), resulting in a 158-year near-total ban on abortion. Very few individuals could access abortion in local hospitals in NI before 2019, and those that could had to meet extremely strict criteria. Many individuals travelled to other parts of the UK to access an abortion, while others attempted to abort using illegal means such as buying abortifacients online. In 2017, individuals from NI were able to travel to England and Wales to access abortion free of charge (both travel and the procedure) (Calkin & Berny, 2021). This was extended to include Scotland in November 2017, although very few service users from NI use Scottish service provisions (Hillen et al., 2022).

Several events led to the 2019 decimalisation of abortion in NI. Firstly, in 2018, an inquiry by the United Nations Convention on the Elimination of All Forms of Discrimination Against Women found that NI was in violation of the convention. This stance was backed by a 2018 Supreme Court Case brought forward by the Northern Ireland Human Rights Commission (NIHRC). Secondly, several high-profile prosecutions relating to abortion occurred from 2015 to 2017. This increased awareness among the general public of the decriminalisation of abortion and the treatment of those experiencing crisis pregnancies, leading to the consolidation of a pro-choice campaign narrative based upon human rights (Calkin & Berny, 2021). In addition, the success of the 2018 campaign to repeal the eighth amendment in the Republic of Ireland (referred to as Ireland hereafter) and legalise abortion boosted the visibility of the cause and provided further momentum.

The opportunity to decriminalise abortion in NI arose in 2019 when the Northern Ireland Executive collapsed, as campaigners then utilised Westminster to pass the Northern Ireland Executive Formation Bill. The Bill was created to provide time in which to form an executive. However, the general public argued that they could not wait for the Northern Ireland Assembly to reform, as the current abortion laws conflicted with individuals' human rights. Stella Creasy MP tabled an amendment in the event that abortion would be decriminalised in NI, should there have been no Assembly by 21 October 2019. This law took effect on 22 October 2019 as there was no sitting Assembly at that time. Abortion in NI is now legal – as of March 2020 – without conditionality up to 12 weeks' gestation, and up to 24 weeks when continuing the pregnancy would put the pregnant individual's physical or mental health at a risk greater than aborting the pregnancy would. Pregnant individuals can abort at any stage when there is a risk to the pregnant person's life, or in the case of foetal abnormality. However, the March 2020 law re-introduced criminal penalties for healthcare professionals who perform 'unlawful terminations'. Stipulations were also brought in to ensure that one medical professional certifies the abortion in emergency situations and two in all other situations (Calkin & Berny, 2021).

Scotland

Scotland, in the same way as England and Wales, is governed by the 1967 Abortion Act. In England and Wales, the Abortion Act amended the Offences Against the Person Act; however, in Scotland it updated a common law framework for abortion. This means that in Scotland, abortion is a common law crime (not created by parliament and not defined in legislation), while it is a statuary crime in England and Wales (created by parliament and defined in legislation). Abortion is a devolved issue, there are some differences in abortion provisions in Scotland (Calkin & Berny, 2021). Firstly, telemedical abortion for the second abortion pill was introduced to Scotland in October 2017. This was before changes were made in Wales (June 2018) and England (December 2018) (Parsons, 2020). Also, in Scotland, abortion is only provided in hospitals as there are no independently run clinics. None of the participants in my programme of research accessed an abortion in Scotland; therefore, I focus upon England, Wales, and NI in the remainder of my programme of research.

Table 1: Abortion law in the UK

Country	Abortion Law	Gestation and Conditionality	Assessed By	Criminal Status of Abortion	Telemedical Abortion Introduced
England	1967 Abortion Act	Under 24 weeks gestation if continuing the pregnancy would cause greater mental or physical harm to the pregnant person than aborting. 24 weeks + severe foetal abnormality or grave permanent danger to the physical or mental health of the pregnant person.	Two doctors	Crime under the 1861 Offences Against the Person Act.	December 2018
Wales	1967 Abortion Act	Under 24 weeks gestation if continuing the pregnancy would cause greater mental or physical harm to the pregnant person than aborting.	Two doctors	Crime under the 1861 Offences Against the Person Act.	June 2018

		24 weeks + severe foetal abnormality or grave permanent danger to the physical or mental health of the pregnant person.			
Scotland	1967 Abortion Act	Under 24 weeks gestation if continuing the pregnancy would cause greater mental or physical harm to the pregnant person than aborting. 24 weeks + severe foetal abnormality or grave permanent danger to the physical or mental health of the pregnant person.	Two doctors	Common law crime.	October 2017
Northern Ireland	The Abortion (Northern Ireland) Regulations 2022	Under 12 weeks without conditionality. 12 weeks – 24 weeks if continuing the pregnancy would cause greater mental or	Under 12 weeks one doctor to confirm the gestation.	Decriminalised for service users.	Under review

	physical harm to the pregnant person than aborting.	12-24 weeks two doctors.
	Any stage emergency situations, severe foetal abnormality, or grave permanent danger to the physical or mental health of the pregnant person.	24 weeks + two doctors.

Abortion as a Criminal Act

Abortion is a criminal act in England and Wales under the Offences Against the Person Act (1861). The Act contains the following offences that are relevant to abortion:

“58 Every woman being with child, who, with intent to procure her own miscarriage shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of an offence and being convicted thereof shall be liable to be kept in penal servitude for life.”

“59 Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of an offence, and being convicted thereof shall be liable to imprisonment for a term not exceeding five years.”

The Act does not make distinctions based on gestation length (6-12 days after ovulation) or whether it is the pregnant person or a third party performing the abortion. It also makes no exception for therapeutic abortion. The Act was passed midway through the reign of Queen Victoria at a time when women did not have the right to vote or own property. Therefore, it does not align with clinical science and modern moral values (Sheldon, 2016). NI has repealed the relevant sections of the Offences Against the Person Act (1861) (Brader, 2020), arguably aligning abortion with 21st century thought. Notwithstanding the changes in NI, there have been no repeals in England and Wales, despite advocacy for change from the Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG), and the British Medical Association (BMA) (Regan & Glasier, 2017), and attempts to pass a ten-minute bill to decriminalise abortion which is currently in the second stage of reading (Abortion Bill, 2018).

The Infant Life Act (1929) was introduced to criminalise ‘child destruction’ in England and Wales. Child destruction is defined as killing an unborn but viable foetus. It was introduced to close the legal loophole where viable foetuses were being killed during the course of birth, by those who did not want children (Griffith, 2016). The 1929 Act assumes that a foetus of 28 weeks is viable; however, in court foetuses of younger gestations have been labelled viable if they are able to breathe independently outside of the womb (Griffith, 2016). Under the Infant Life Act (1929), killing a viable foetus is not a criminal offence if the act is performed in good faith to preserve the life of the pregnant person. The Criminal Justice Act (Northern Ireland) (1945) criminalised ‘child destruction’ in the same way the Infant Life Act (1929) does. However, this was revoked when abortion was legalised in NI.

It is rare for the police to investigate an illegal abortion, and prosecutions are even rarer. However, there have been a handful of recent British cases where individuals have been subjected to traumatic and lengthy criminal proceedings. For instance, in the summer of 2022, two women were reportedly facing life imprisonment for illegal abortion (Proudman, 2022). In the first case, a 25-year-old allegedly took misoprostol illegally, but her baby was born alive, and she was subsequently reported to the police. She is being charged under the Offences Against the Person Act (1861). In the second case, a woman allegedly took abortion pills at 28 weeks’ gestation, having obtained them from the British Pregnancy Advisory Service (BPAS) by post. She was imprisoned for 28 months in 2023 after pleading guilty under the Offences Against the Person Act (1861), prior to this she pleaded not guilty to a charge of child destruction (Thomas, 2023).

Changes surrounding abortion law have been brought into action through the Human Fertilisation and Embryology Act (1990) and these were discussed further when the Human Fertilisation and Embryology Act (2008) was presented. The 1990 Act lowered the gestation limit from 28 to 24 weeks for abortion when preventing ‘mental or physical injury’, due to the advancement of medical technology. However, gestation restrictions were removed for ‘late term’ abortions in cases of grave physical and mental injury, risk of life, and disability of the foetus. The 2008 Act did not contain any clauses specific to abortion; abortion amendments were proposed but were unsuccessful.

In addition, subsequent law changes were proposed in 2017 when Labour MP Diana Johnson introduced the Reproductive Health (Access to Terminations) Bill (2017) with the aim of repealing criminal law on abortion in England and Wales. The Bill is currently in the second reading stage.

Types of Abortion

In general, there are two types of abortion: medical and surgical. Medical abortions are administered with two tablets which induce miscarriage and are performed up to 10 weeks' gestation (NHS, 2020). Medical abortions are the most common form of abortion in England and Wales, accounting for 87% of the total number of abortions in 2021 (Department of Health and Social Care, 2023) and 56% of abortions in Northern Irish hospitals in 2020/21 (Hillen et al., 2022). This figure has increased in England and Wales since 1991 when mifepristone was first licensed in the UK (Department of Health and Social Care, 2023). Pregnant individuals in England, Scotland and Wales are now able to take both of the tablets at home without the need to attend a clinic or hospital (Haynes, 2020). This is the most common form of abortion, with 57% of all abortions in 2021 in England and Wales being performed in this way. Alternatively, surgical abortions occur with the service user under local/general anaesthetic or conscious sedation. These procedures can range from suctioning to dilation and evacuation of the foetus depending on the gestation and other circumstances relating to the individual accessing abortion. Suction aspiration can occur up to 14 weeks gestation, while dilation and evacuation is used after 14 weeks gestation (NHS, 2020). Only 13% of abortions in England and Wales in 2021 were surgical (Department of Health and Social Care, 2023), compared with 44% of abortions in Northern Irish hospitals (Hillen et al., 2022).

Surgical abortions can be 'late terminations' (those after 20 weeks' gestation). Abortions can be conducted after 24 weeks in limited circumstances – for example, if the child were to be born with a severe disability or if the pregnant person's life is at risk (NHS, 2020).

Technological advancements in healthcare have altered the face of foetal medicine and ‘late abortions’. There has been a growth in knowledge surrounding ultrasound, antenatal screening, foetal physiology, and an emphasis on detecting foetal abnormalities. This has increased the number of ‘late abortions’ and brought new ethical issues to the table. For example, aborting due to abnormalities such as cleft palate and lip, and aborting ‘late term’ more generally due to viability (Moodley, 2008).

The Roles of Healthcare Professionals in Abortion

In the following section, I explore the roles of doctors, GPs, midwives, and nurses in abortion in the UK. I do not explore the role of the pharmacist during my programme of research.

Under UK law, only doctors can perform surgical abortions and prescribe abortifacient (medical abortion). Doctors who provide abortion care often specialise in obstetrics and gynaecology and perform the following tasks: authorising abortions in line with the law and ensuring all the paperwork is complete, overseeing and enabling the work of other staff and healthcare professionals involved in abortion care, performing abortions (hands-on), and in some cases developing and planning the services in their region (Lee et al., 2017). In the UK, GPs do not participate in the abortion (surgical and medical) from a hands-on perspective. Instead, they ask the pregnant person a series of questions to ascertain the reason for the abortion so they can make a decision ‘in good faith’ as to whether to permit the abortion (Sexual Health Policy Team, 2014). They will then sign the relevant bureaucratic (HSA1) form; this acts as a formal referral and once signed by another doctor (who may not meet the service users), enables the service user to access an abortion (Cowley, 2017).

Traditionally, midwives are involved in being ‘with women’ throughout their pregnancy journeys from conception to the postnatal period. However, in recent years, the role of the midwife has extended to include abortion care (Ramsayer & Fleming, 2020). In fact, the World Health Organization (WHO) has designated midwives as key providers of abortion care (World Health Organization, 2015). Those midwives who choose to accept this extension of midwifery care are required to treat service users with respect and to support their individual needs and wishes, in keeping with other procedures relating to sexual and reproductive health (Ramsayer & Fleming, 2020; The Royal College of Midwives, 2016). Midwives who are involved in abortions may be asked to: administer abortifacient drugs, accompany the pregnant person during their labours, deliver the placenta and foetus, impartially counsel the service user through the decision-making process, signpost the service user, care for the service user before and after the abortion in a maternity unit under obstetric care, manage uncomplicated incomplete abortions or miscarriages with misoprostol, set up IV drugs for mid trimester abortions and provide emergency care (e.g., early detections of deviations from normal recovery such as cases of sepsis and haemorrhage) (Ramsayer & Fleming, 2020; World Health Organization, 2015). The role of the midwife covers both first and second trimester abortions. Findings suggest that midwives who are involved in second trimester abortion care must cater to different emotional needs. For instance, they may have to provide discrete care to prevent judgement from others for having an abortion and reaffirm service users as moral decision makers (Altshuler et al., 2017).

In the UK, the role of the nurse in abortion is very similar to that of the midwife. Nurses do not perform surgical abortions or prescribe abortion pills, even though they perform other gynaecological procedures such as colposcopies, hysteroscopies, and the insertion of intrauterine devices (Wakley, 2007). In the same way as midwives, nurses provide psychological care and reduce stigma using non-judgemental counselling and interpersonal skills (Mainey et al., 2020) and perform the same abortion-related tasks I discussed previously. Owing to the low number of abortion providers, there have been calls to increase the scope of the roles played by non-specialist doctors, midwives, and nurses in the UK to enable them to perform surgical abortions, and for nurses and midwives to be able to prescribe abortion pills (World Health Organization, 2015).

Availability of Services

The majority of abortions (99% in England and Wales in 2021) are funded by the NHS (Department of Health and Social Care, 2023). Of these, 21% (in 2021) were performed in NHS hospitals and 77% were performed in NHS-funded independent advisory services such as BPAS and MSI Reproductive Choices ((MSI) formerly Marie Stopes International) (Department of Health and Social Care, 2023). Abortion service users are not automatically entitled to NHS-funded services; however, the majority of individuals seeking an abortion in the UK do not have to pay to access this service (Lee et al., 2004).

COVID-19 has had a substantial impact on how service users access abortion and the barriers to abortion. Medical abortion has become more widely available with the introduction of tele-medicine. This means that service users in the UK (excluding NI) can take medical abortion tablets at home without having to visit a clinic. By contrast, some countries, including Australia, require service users to attend an ultrasound appointment before they can use telemedical services (Sifris & Penovic, 2021). Making service users attend an appointment prior to telemedical abortion may create problems for those living in rural, remote, and isolated areas, issues that were exacerbated by the lack of freedom of movement across geographic areas during the COVID-19 pandemic (Sifris & Penovic, 2021). Such issues should not occur in the UK if service users are aware of this service and have access to a telephone.

In addition, although telemedicine has improved access for those seeking medical abortion, COVID-19 has created barriers for service users requiring surgical abortion. In the UK, most sexual health services were closed during the pandemic. This, alongside the cost-of-living crisis and NHS staff shortages, created barriers for individuals attempting to access abortion. Thus, currently more individuals are seeking abortions (due to financial insecurity) and there are significantly fewer services available. Healthcare professionals describe the situation as terrifying, as individuals are having to wait several weeks before they are seen, or are travelling hundreds of miles for appointments (Hough & Moore, 2023). Thus, the system of commissioning for abortion care in the UK has created variations in access to abortion care across the UK (The Royal College of Obstetricians and Gynaecologists, 2022).

In June 2017, it was announced that pregnant individuals seeking abortion who reside in NI could travel to England or Wales to access an NHS funded abortion. This was extended to include Scotland in November 2017, although very few service users from NI use Scottish service provisions (Hillen et al., 2022). In 2018, 1,008 Northern Irish service users accessed an NHS-funded abortion in England and Wales, a figure that fell to 146 individuals in 2021 (Hillen et al., 2022). This decrease in Northern Irish service users accessing abortion in England and Wales could reflect the legalisation of abortion in NI. However, only 150 abortions were performed in NI in 2021 (Hillen et al., 2022). These figures are problematic as only 296 abortions were performed overall (in NI and England and Wales) on Northern Irish service users in 2021, indicating a massive drop in the number of abortions obtained by Northern Irish service users overall. This decrease has been attributed to travel restrictions in England and Wales caused by COVID-19 and a lack of awareness of the availability of abortion locally (Armitage, 2022). However, an alternative hypothesis not proposed by Armitage (2022) is that, alongside the lack of travel to England and Wales, there were insufficient abortion provisions in NI in 2021. This hypothesis is more likely as the Houses of Parliament noted gaps in abortion service provisions in March 2021, gaps that were still apparent in March 2022 (Rough, 2023).

An Introduction to Conscientious Objection

For the last half century, healthcare professionals have had the right to object to providing service users with care which they deem unethical on conscientious grounds. There is little dispute around the definition of conscientious objection (Wester, 2015) and there is a general consensus that it encompasses elements of the following:

“In the context of healthcare, physicians, nurses and pharmacists engage in acts of conscientious objection when they: (1) refuse to provide legal and professionally accepted goods or services that fall within the scope of their professional competence, and (2) justify their refusal by claiming that it is an act of conscience or it is conscience-based" (Wicclair, 2011, p.1).

Moreover, conscientious objection is enshrined in UK law, as the fourth clause of the 1967 UK Abortion Act legally permits healthcare professionals in England, Scotland, and Wales to object to participating in abortion:

"4. Conscientious objection to participation in treatment

(1) Subject to subsection (2) of this section, 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.

(2) 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.

(3)In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section" (Abortion Act, 1967, para. 4).

However, the 1967 Abortion Act was not extended to NI. Instead, The Abortion (Northern Ireland) Regulations (2022) stipulates NI's abortion law. This is a *de novo* framework that has clearly been informed by the 1967 Abortion Act. More specifically, the conscientious objection clause mirrors the 1967 Abortion Act. Part 7 of The Abortion (Northern Ireland) Regulations 2022 presents the law surrounding conscientious objection:

"Conscientious objection to participation in treatment authorised by these Regulations

(1) Except as provided by paragraph (3), a person is not under a duty to participate in any treatment authorised by these Regulations to which the person has a conscientious objection.

(2) Paragraph (1) applies whether the duty arises under contract or under any statutory or other legal requirement.

(3) Paragraph (1) does not 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.

(4) In any legal proceedings the burden of proof of conscientious objection rests on the person claiming to rely on it" (The Abortion (Northern Ireland) Regulations, 2022, para. 7).

Although healthcare professionals have a right to protect their conscience, both laws consider the impact on service users in certain situations. They clearly state that healthcare professionals cannot object in emergency situations when the service users' life is at risk, or when their physical or mental health faces grave and permanent injury (Abortion Act 1967; The Abortion (Northern Ireland) Regulations 2022). However, conscientious objection goes unregulated in the UK. Objectors do not have to legitimise their objection – as is done in the military context – and do not have to notify a regulatory body, although they are required to notify their employer.

Regulatory Body and Trade Union Guidelines Around Conscientious Objection

All doctors in the UK are required by law to register with the General Medical Council (GMC), and midwives and nurses with the Nursing and Midwifery Council (NMC). It is then optional for them to join a trade union such as the BMA, the RCM, and the Royal College of Nursing (RCN). Those who object are obligated to follow the guidelines stipulated by the regulatory bodies. These reinforce the 1967 Abortion Act and present additional parameters which go unregulated. The GMC and the NMC support healthcare professionals in objecting, provided they treat patients fairly and with respect. However, they state that services users’ rights are paramount and take precedence over the right to object (General Medical Council, 2020a; Nursing and Midwifery Council, 2018). This stance is also adopted by the BMA which states that “a doctor’s primary obligation is his or her [(or their)] patient. Where a conflict arises between the interests of a patient and a doctor’s freedom to exercise a conscientious objection to manifest belief, the conflict must be resolved in favour of the patient” (British Medical Association, 2020, p. 5). This is reiterated by the other trade unions.

Moreover, paragraph 4.4 of the NMC Code presents the following guidelines for midwives and nurses who wish to object: “tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure” (Nursing and Midwifery Council, 2018, p. 8). It states: “make sure you do not express your personal beliefs (including political, religious, or moral beliefs) to people in an inappropriate way” (Nursing and Midwifery Council, 2018, p. 8). Thus, the NMC believes there should be transparency around the objection and all parties should be aware that care is being transferred due to a conscientious objection rather than for medical reasons. This should be translated in a professional manner without judgement. The RCN concurs, arguing that handling an objection in this manner is essential in establishing a successful therapeutic relationship (Royal College of Nursing, 2020).

This stance on transparency and judgement is reiterated in the GMC’s Good Medical Practice which states that “[y]ou [(the doctor)] must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient’s lifestyle, choices or beliefs” (General Medical Council, 2020a, para 52). Thus, for doctors to object, they must inform the service user that they can see another doctor to discuss their options and inform them of their objection without expressing disapproval. This is reiterated in the BMA’s guidelines (British Medical Association, 2020).

Conversely, the NMC makes it clear that it is the duty of the objecting nurse or midwife to refer the service user to a non-objecting colleague, as its Code states that objectors have a duty to "arrange for a suitably qualified colleague to take over responsibility for that person's care" (Nursing and Midwifery Council, 2018, p. 8). However, guidance on referring the service user is slightly more ambiguous in the GMC's Good Medical Practice, it states that "if it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role" (General Medical Council, 2020a, para 52). Therefore, it seems that it is at the doctor's discretion whether they refer the service user to another colleague, or whether the service user must navigate the process of securing another appointment with a GP. However, doctors "must not obstruct patients from accessing services or leave them with nowhere to turn" (General Medical Council, 2020b, para 15). Moreover, it is important to distinguish between a GP objecting and referring a service user to another GP who will take over their role, and a GP making a formal referral. In the case of the latter, they sign the relevant bureaucratic form and the service user is formally transferred within the health service (Cowley, 2017).

The RCM states that midwives are only able to object to "direct involvement in the procedure of terminating pregnancy" (The Royal College of Midwives, 2016, para 8). This is a similar stance to the RCN which instead lists what nurses cannot object to such as providing care for a service user before or after the abortion or in emergency situations (Royal College of Nursing, 2020). This guidance aligns with the stance of the Supreme Court on participation in the Doogan and Wood case (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland', 2014). Similarly, the BMA states that "[t]he limits of conscientious objection in abortion were confirmed in the UK case of Janaway v Salford Area Health Authority (1988) UKHL 17 which held that the right is limited to a refusal to participate in the procedure(s) itself and not to pre- or post-treatment care, advice, or management" (British Medical Association, 2020, para 7) and concluded that doctors can only object in non-emergency situations. Outlining the court case may create confusion, as it seems the BMA is presenting this as an example of what doctors can and cannot object to. This contradicts the guidance provided.

The GMC and the NMC provide guidance that is vaguer than that of the trade unions. The GMC merely comments that “[y]ou may choose to opt out of providing a particular procedure because of your personal beliefs and values” (General Medical Council, 2020b, p. 8). Similarly, the NMC does not explicitly outline what healthcare professionals are able to object to (Nursing and Midwifery Council, 2018). This lack of clarity from the NMC and the GMC perhaps reflects the contentious nature and lack of agreement over what is meant by ‘participating in abortion’.

Conscientious Objection in Practice

It is argued that service users can bypass objecting GPs in the UK as they can self-refer to NHS-funded pregnancy advisory services, and thus do not have to come into contact with a GP to access abortion (Chavkin et al., 2017). The statistics seem to indicate that the majority of service users are bypassing these gatekeepers, as 77% of abortions in England and Wales in 2021 were performed in NHS-funded independent sector clinics such as BPAS and MSI (Department of Health and Social Care, 2023). The prevalence of these services has led scholars to downplay or disregard the impact that conscientious objection could have on service users in the UK (Tongue, 2022). However, these conclusions should be treated with caution as they do not consider service users who have been referred to these services by a GP, or who have sought these services themselves after lack of referral from a GP. In fact, MSI notes that the majority of their service users are referred to them by GPs (MSI Reproductive Choices, 2020).

Moreover, in the UK, the number of objectors and service users who have experienced conscientious objection is not documented, meaning the prevalence and impact of conscientious objection cannot be assessed. It can be deduced that there are high numbers of objectors in UK hospitals, as in 1994, the Department of Health published guidelines that mean abortion duties can now be included in job adverts and potential employers can now question applicants’ beliefs (Parliament UK, 1999); however, there is insufficient evidence to reach this conclusion. Furthermore, Cowley (2016c) downplays the number of objectors in the UK, arguing that conscientious objection is not problematic as other healthcare professionals are always available to take over the role of objectors. Thus, more research is needed to determine the actual number of objectors, whether conscientious objection is impacting service users in the UK, and to what extent.

The Missing Voices

Previous research discussing conscientious objection focuses on the understandings, views, and experiences of healthcare professionals (primarily medical practitioners) (Combs et al., 2011; Curlin et al., 2007; Fiala et al., 2016; Freeman & Coast, 2019; Lawrence & Curlin, 2009; Nordberg et al., 2014; Nordstrand et al., 2014; Soengas & Ramos, 2020; Strickland, 2012; Toro-Flores et al., 2019), proceeds on the basis of an ideological commitment to defending/opposing conscientious objection (Cowley, 2016c; Fiala & Arthur, 2014; Schuklenk & Smalling, 2017; Wicclair, 2011), and often debates the impact conscientious objection has without consulting individuals who have accessed abortion (Fleming et al., 2018; Freeman & Coast, 2019; Stulberg et al., 2012).

Whilst undertaking my programme of research I offered a unique perspective. I adopted a purposive premise, and provided a platform for women and those who can become pregnant to voice their valuable views and experiences at a time when their voices are largely excluded from the great tradition of Western political philosophy and law-making processes (Dickens, 2014; Levit et al., 2016; Okin, 2013; Paxton & Hughes, 2007). Hence, I provided a platform for service users to have their say on matters that have the potential to impact their reproductive rights, whilst challenging the systematic devaluation of their voices in the context of patriarchy (Beard, 2017). Previous attempts have been made to include the voices and experiences of women in some areas of law and policy creation (Carra, 2008), I present findings and conclusions in my programme of research that extend this practice to conscientious objection to abortion.

Previous research provides an insight into how conscientious objection is occurring in Vancouver (Wiebe & Sandhu, 2008), Victoria, Australia (Keogh et al., 2019), Croatia

(Håkansson et al., 2021), Scotland (Purcell et al., 2014), London (Kumar et al., 2004), and South Durham (Finnie et al., 2006). Findings from non-UK countries cannot, however, be extrapolated or compared with the UK due to the different cultural and legal contexts of abortion. Additionally, research focusing on UK service users is outdated and aims to understand and assess service delivery, rather than explore conscientious objection. Thus, there is only a small contribution previous research can offer regarding conscientious objection.

Furthermore, there is a missing narrative within the previous research, as service users' views on conscientious objection have not been explored, and their experiences around conscientious objection have not been sufficiently researched. Academics have suggested that the impact of conscientious objection from the service users' perspectives needs to be examined (Fleming et al., 2018; Freeman & Coast, 2019; Stulberg et al., 2012), as such research could illuminate service users' experiences, emotional responses, and course of action when they are refused care (Chavkin, 2013). I aimed to fill this gap in the literature with my programme of research by providing a detailed account of service users' experiences of conscientious objection, as well as their views on conscientious objection in practice.

Research Questions

I aimed to answer the following questions:

1. What are the abortion journey experiences of service users in the UK?
2. Have conscience clauses in abortion legislation affected UK service users' reproductive rights regarding access to and experience of abortion? In what ways?
3. What do service users understand as constituting 'participation in abortion'?
4. How do service users situate themselves regarding Wicclair's (2011) three-part framework? (I outline this framework on page 62).

Research Rationale

The main contributors to debates surrounding conscientious objection are philosophers, lawyers, and ethicists. Minimal research has been undertaken to understand what is happening in practice regarding conscientious objection globally, including, for the interests of my programme of research, in the UK. Additionally, the literature that does focus on researching conscientious objection does so from the perspective of healthcare professionals, thus failing to present the impact of conscientious objection on service users from their perspectives. This is problematic, not only regarding practical application (Chavkin, 2013; Freeman & Coast, 2019; Stulberg et al., 2012), but also in relation to power, as only those in positions of power are being heard. I have attempted to rectify this by providing a platform for UK-based service users to share their experiences and views of conscientious objection in order to understand both sides of the debate and challenge the unequal paternalistic power dynamics within healthcare (Shahvisi, 2018).

Furthermore, uncovering service users' perspectives of conscientious objection is of growing importance in view of claims from the WHO that conscientious objection is a fundamental barrier preventing service users from accessing abortion. This is reflected in the following statement: "[r]efusal of abortion care on the basis of conscience operates as a barrier to access to safe and timely abortion, […] and unregulated conscientious refusal/objection can result in human rights violations, or lead women to seek unsafe abortion" (World Health Organization, 2022, p. 60). Such claims highlight the importance of understanding the impact of conscientious objection on service users.

Furthermore, my programme of research is paramount in light of factors surrounding legal changes around abortion and, more specifically, conscientious objection. Firstly, there is continuing controversy around various aspects of abortion practice, including an ongoing campaign to decriminalise abortion (UNISON, 2022), which would render the existing conscience clause ineffective; calls for further restrictions on the time limits on abortion (Oppenheim, 2022); advances in technology that could redefine the age of viability (Di Stefano et al., 2021); and changes in abortion provision that have brought a wider range of healthcare professionals into contact with abortion and continue to do so (Fleming et al., 2020). In addition, during the course of my programme of research, COVID-19 changed the face of abortion care with the introduction of rules allowing individuals to take both tablets for a medical abortion at home in England, Scotland, and Wales (Boydell et al., 2021). This has reduced the number of healthcare professionals who encounter service users attempting to access abortion and has the potential to create new, unexplored issues surrounding conscientious objection.

Also, during my programme of research, abortion became a topical debate among the general public. Anti-abortion rhetoric was brought to the forefront with the overturning of *Roe V Wade* in the US, removing abortion as a constitutional right (Glenza et al., 2022) along with the appointment of the anti-abortion UK minister for women Maria Caulfield (Ariyanayagam, 2022). Such changes have the potential to impact legislation surrounding abortion and conscientious objection in the UK, including attempts to widen the scope of conscientious objection. Such endeavours have already occurred, as exemplified by the prorogued Conscientious Objection (Medical Activities) Bill 2017-2019 where an attempt was made to allow healthcare professionals to object to 'participating in an activity' whose extension was broadly defined to include "any supervision, delegation, planning or supporting of staff in relation to the activity to which a practitioner objects" (Wicclair, 2019, p. 540).

Finally, the importance of my programme of research lies in its potential to inform national governance, management, and practice in medicine and education, with a particular focus on GPs. It could also be used to influence policymaking by international organisations such as the WHO and international professional bodies and trade unions including, but not limited to, the GMC, NMC, BMA, RNC, and the RMC. Understanding service users' perspectives when revising and creating policy and guidelines is vital.

A Note on Language and Inclusion

I would like to discuss some language choices I have made throughout my programme of research. The first relates to my use of the term 'abortion' and the second is my decision to use the term ‘service user’ rather than ‘woman’ to refer to those who have accessed abortion. The final choice concerns my use of the term ‘healthcare professional’.

Use of the Term ‘Abortion’

I use the term ‘abortion’ throughout this thesis to refer to the voluntary termination of pregnancy. I do not use it to include ‘spontaneous abortion’ (miscarriage). During Phase one of recruitment, I used the phrase ‘abortion/termination for foetal anomaly for medical reasons’ after I was advised by an abortion counsellor that service users who abort later in a pregnancy for medical reasons may not wish to use the term ‘abortion’. I did not use this language during the interviews as none of my participants were recruited from this counselling service. During the interviews, all participants either used the word ‘abortion’ or the terms ‘termination’ and ‘abortion’ interchangeably.

Use of the Term ‘Service User’

I use the terms ‘service user’ and ‘pregnant person’ throughout my programme of research to describe those who have accessed abortion or who have attempted to do so. It is argued that gender neutral terminology should be used when discussing reproductive rights to prevent the exclusion of individuals who do not identify as women, but can become pregnant (Rioux et al., 2021). Additionally, it is argued that using the term ‘woman’ to describe individuals who can become pregnant and have abortions implicitly lends support to transphobic and essentialist discourse. It also erases and misgenders individuals who do not identify as women who access abortion services (Rioux et al., 2021). Critics argue that using gender-neutral terms when discussing elements of healthcare traditionally associated with women (in practice) can erase and dehumanise women and create confusion around services – particularly for those with limited knowledge of the English language (Dahlen, 2021). However, using gender-neutral phrases in academia has not attracted a substantial backlash, as it does not have potential real-world repercussions (Dahlen, 2021). Thus, I use gender-neutral terminology throughout this programme of research to create inclusive research.

Use of the Term ‘Healthcare Professional’

I use the term ‘healthcare professional’ to include midwives, doctors, nurses, and pharmacists. However, my discussions with participants within the interviews focused on midwives, doctors (including GPs), and occasionally nurses. Service users’ views of pharmacists’ right to conscientiously object was not raised. Therefore, I have not included the literature on pharmacists in the literature review.

Overview of the Research Approach

I employed a liberal feminist theoretical framework to understand service users’ experiences of and views on of conscientious objection. I employed a hybrid interview approach and utilised a combination of both narrative and semi-structured interviews. I interviewed 25 participants over the phone or using Voice over Internet Protocol (VoIP). Of these, five participants had experienced conscientious objection, eight had experienced non-smooth access or treatment for reasons that may or may not have been conscience based, and 12 had not experienced conscientious objection. I gained ethical approval internally from Liverpool John Moore’s University Ethics Committee.

I transcribed interviews verbatim and imported them into NVivo 12. I analysed participants’ experiences and views separately. I analysed their experiences and presented them using found poetry. I examined their views using a reflexive liberal feminist thematic analysis approach and drew on Braun & Clarke's (2013) and Clarke & Braun’s (2021) guidelines as a framework. In addition, I understood the findings in relation to Wicclair’s (2011) three ethical standpoints on conscientious objection: (i) the incompatibility thesis, proponents of which believe healthcare professionals should not be allowed to object; (ii) conscience absolutism, supporters of which believe that healthcare professionals should be able to object to whatever they wish; and (iii) compromise (which I refer to as the middle-ground approach hereafter, to avoid loaded language), proponents of which argue that healthcare professionals should be able to object so long as it is a non-emergency situation, no undue burdens are placed on the service user, and the healthcare professional informs and refers the service user. I assessed the quality of the study using Guba and Lincoln’s (1985) criteria of trustworthiness.

Research Implications and Contribution

I created this programme of research to be this first of its kind to investigate the impact of conscientious objection on service users in the UK, as well as service users’ views on conscientious objection. I provide a unique insight into their experiences and opinions regarding conscientious objection and make a valuable contribution to knowledge on conscientious objection, corresponding practice, and national policy and guidelines.

In the findings I reveal a detailed picture of the abortion journeys of participants who have and have not experienced conscientious objection, as well as the impact of conscientious objection on service users. I illuminate the lack of education around self-referral for abortion and the reliance that this creates on GPs. This leads to the inference that the conscience clause may not be bypassed to the extent it is believed. I also indicate that service users do not seek advice on abortion from healthcare professionals as many participants had already made the decision to abort, unless they had been coerced into an abortion by family or a partner. This may impact how morally complicit a healthcare professional feels informing service users about abortion, the type of information they wish to pass on, and the impact an objection or the advice provided has on a service user.

I also reveal that service users experience mixed treatment from both objecting and non-objecting healthcare professionals, ranging from acting positively and offering them support to treating them with distain and disrespect. Lack of transparency is common from both objecting and non-objecting healthcare professionals, meaning service users can often become confused as to whether such professionals are objecting for reasons of conscience. I suggest that clearer guidelines are needed around how healthcare professionals treat service users and that professionals should be more transparent regarding their decision-making.

Moreover, I reveal that some healthcare professionals are acting in accordance with policy and guidelines, as they are acting non-judgmentally, informing service users of their own objection and ensuring they have the information to make another appointment. However, not all healthcare professionals act in this way as I highlight improper treatment such as: not informing service users that they have an objection, not informing them that they can access an abortion, attempting to persuade service users not to abort using misinformation and moral arguments, and not informing service users of their right to discuss their options with another healthcare professional. This has emotional repercussions as participants were sometimes left feeling hopeless, scared, and distressed. Nevertheless, all participants were able to access abortion in a timely manner. No previous research has explored conscientious objection in this way, and I conclude that more training and regulation is required for healthcare professionals.

I illustrate that service users (who have or have not experienced conscientious objection) have mixed opinions on all aspects of conscientious objection, including issues around the entitlements of healthcare professionals and service users such as rights, respect, freedom, and civil liberties. Also, participants expressed mixed views on the impact conscientious objection has regarding whether they feel judged by the actions of healthcare professionals, the impact of no referral, effective referral (abides by policy and guidelines), and the outcome of no referral. The nature of conscientious objection, participants' expectations of healthcare professionals and how these differ based on their occupational role and what constitutes 'participation' in abortion were also issues on which participants had differing views. Participants also had a plethora of views on how conscientious objection is and should be organised, including: whether we should retain the current system in the UK; whether healthcare professionals should be transparent; whether they should refer; and if and/or how conscientious objection should be regulated. Although there was agreement over the role of the NHS, the fact that abortion should be available in the UK, and that people of colour (POC) and those in poverty are disproportionally impacted by conscientious objection, few participants discussed these topics.

Finally, the topic of conscientious objection often elicited contradictory views from individual participants, reflecting a non-uniform approach to conscientious objection. This highlights the complex and multifaceted nature of conscientious objection. It also triggers new debates and understandings surrounding this phenomenon, as service users' views of conscientious objection have not previously been explored.

Outline of the Programme of Research

In Chapter 2, I present a review of the literature on conscientious objection, starting with how conscience is defined and the arguments around why it should be preserved in healthcare. I then discuss why healthcare professionals conscientiously object and review the ethical perspectives regarding conscientious objection using Wicclair's (2011) three-part framework. Although Wicclair has continued to publish relevant articles, his 2011 book offers the most in-depth and comprehensive overview of his stance on conscientious objection; moreover, this remains unchanged in his more recent work, which is why I have referenced this work.

Next, I present legal perspectives on conscientious objection, discuss how it is protected as a fundamental human right and consider how the scope of conscientious objection has been challenged legally. I then explore healthcare professionals' views of what constitutes participation in abortion, and the debates concerning institutional conscientious objection. Following this, I examine the limited amount of research that has been conducted on the abortion journeys of service users who have experienced conscientious objection and discuss how conscientious objection is impacting service users at both the healthcare professional level and the healthcare system level. To conclude, I review the literature on how and if conscientious objection should be regulated.

In Chapter 3, I present the methodology underpinning the research. I discuss feminist constructivism, interpretivism, liberal feminist theory, and Wicclair's (2011) ethical framework, as I used these elements to guide the research philosophically and theoretically. Thus, they informed my selection of a qualitative research design. I then discuss the methodology that I employed, including: recruitment, participant demographics, choice of interview mode, and why I used a hybrid interview approach (narrative and semi-structured). I then explain how I incorporated feminist methodology into my programme of research. I offer a reflexive account of how my own positionality and subjectivity informed and impacted the research. I then discuss the context of abortion in the UK and describe how ethical approval was obtained and how cultural assumptions influenced the requirements of the ethics committee. Next, I outline how I prepared and managed ethical issues. Following this, I detail how I undertook the analysis. I conclude the chapter with a discussion on how 'quality' was ensured throughout the research.

In Chapter 4, I present and analyse participants' abortion journeys using found poetry and discuss the research findings.

In Chapter 5, I present the findings of the feminist thematic analysis in sections entitled: healthcare professional and service-user entitlement, contextualising conscientious objection, organising conscientious objection, the impact of conscientious objection, and the nature of conscientious objection. I summarise these themes with an overview of participants' ethical perspectives.

In Chapter 6, I conclude the study and outline the key findings and the significance of the research. I review its overall strengths and limitations and offer suggestions for policy, guidelines, and practice. Finally, I present recommendations for future research.

Chapter Two: Literature Review

Introduction

In this literature review, I outline the ethical debates and legal frameworks around conscientious objection, and document and critique the research evidence on its impact. I did not identify any studies that document service users' views or understandings of conscientious objection and few studies that provide insight into service users' experiences of conscientious objection, thus indicating the importance of my programme of research. I identified eight areas as key in providing suitable literature in view of my aims and objectives: defining conscience, understanding why healthcare professionals object, ethical debates around conscientious objection, conscientious objection in UK law, defining 'participation' in abortion, institutional conscientious objection, the barriers, and impact of conscientious objection, and regulating conscientious objection. In this review I focused on literature relating to conscientious objection and abortion but excluded any consideration of the ethics of abortion or military conscientious objection.

I utilised Kable et al.'s (2012) 12-step guidelines for conducting a systematic review, along with snowballing (Badampudi et al., 2015). I employed both methods, as it has been reported that the efficiency of snowballing is comparable to a systematic database search and can be more reliable when there is a comprehensive set initially (Badampudi et al., 2015). My database search therefore provided the initial literature from which to snowball, thereby enhancing the reliability of the literature review.

Literature Search Strategy

In table 2 I present the databases I used in the search. I utilised the following keywords and combinations of keywords to identify relevant literature: 'conscientious objection', 'conscientious objection healthcare', 'conscientious objection abortion', and 'conscientious objection termination'. I used Booleans such as AND, OR and NOT to exclude military conscientious objection and focus on conscientious objection to abortion. I used specific keywords and combinations in each database to narrow the search results. I set no time parameters in relation to the search, as this may have removed important sources. The literature needed to be relevant and available in English.

Once I had compiled the literature and deleted duplicates, I uncovered key texts and thinkers. I investigated these further using Google Scholar to compile a complete picture of the relevant work. I then utilised snowballing, whereby I examined the references of key texts, key areas, and unique texts to procure further literature.

Table 2: Literature review strategy

Literature Classification	Search Strategy	Source
Academic Literature	Online databases	Web of Science PubMed MEDLINE JSTOR Hein Online Taylor and Francis PsycInfo EBSCO Scopus
Academic Literature	Snowballing (manual search by citation/reference)	Key texts Key areas Unique articles
Academic Literature	Google Scholar	Wicclair, Fleming, Cowley, Fiala and Arthur, Card, Chavkin, Savulescu, Schuklenk.
Grey Literature	Grey literature databases	Google Scholar Open Grey

		Ethos, Pro Quest (Theses’) UN digital library UN data Parliament (UK)
Media	Media databases	The British Newspaper Archive *The Guardian* *The Times* *The Independent*

Once I had gathered the relevant papers in Endnote, I created a summary table in Excel. I outlined the author(s), title of each paper, a brief overview, the stance on conscientious objection, articles that support/reject the proffered stance, and my own thoughts on the paper (criticism). I created the following literature review from this process.

Understanding Conscience

Conceptions of Conscience

The majority of literature on conscientious objection pays little attention to conceptualising conscience. Thus, according to Sulmasy (2008), a definition of conscience is rarely stated. However, it is important to note that since Sulmasy made this statement, academics have begun to discuss how one should define conscience when writing on the topic of conscientious objection (Brock, 2008; Fleming et al., 2019; Wicclair, 2011). There are several definitions and conceptions of conscience. Such definitions are varied, often contradictory, and formed on both a secular and religious basis. Benjamin (1995) identifies a simplistic yet logical framework which divides conceptions of conscience into three main perspectives: an inner self-validating sense of right or wrong, the product of internalising societal and parental norms and values, and an expression of integrity, the latter of which is the dominant contemporary conception

(Antommaria, 2010). In the following section, I employed Martin Benjamin’s framework to discuss definitions and conceptions of conscience.

The first conception of conscience serves an epistemological function, whereby conscience is a faculty that distinguishes between right and wrong, makes ethical judgements, and discerns moral truths (Wicclair, 2011). If this definition of conscience is proffered, one could argue that conscience is an innate phenomenon which is ingrained into our very being. This definition underpins Joseph Butler’s conception of conscience:

“[T]here is a superior principle of reflection or conscience in every man, which distinguishes between the internal principles of his heart, as well as his external actions’ which passes judgement upon himself and them; pronounces determinately some actions to be in themselves, just, right, good; others to be in themselves evil, wrong, unjust: which without being consulted, without being advised with, magisterially exerts itself, and approves or condemns him, the doer of them, accordingly” (Butler, 1827, p. 53).

Moreover, this conception of conscience implies that there is an objective moral order, which becomes known to the individual as their conscience develops. However, this argument has been largely rejected as being too simplistic. Sulmasy (2008) comments that if conscience were an ‘inner voice’, moral debates would be rendered unnecessary, as philosophers would simply advise ‘follow[ing] your conscience’ in relation to morality.

Furthermore, this inner voice can be labelled ‘the voice of God within’, meaning it is the source of knowledge of God’s will. Conscience does not have direct access to the source of knowledge, but rather is a ‘witness’. In Christianity, Islam and Judaism conscience allows moral agents to know whether they are doing right or wrong by God’s standard (Curlin et al., 2007; Lawrence & Curlin, 2007). Thomas Aquinas believed that conscience is the act of applying divine law to real-world situations. The innate ability of the mind (synderesis) apprehends divine laws. The role of conscience is to then apply what is learnt from synderesis. However, this knowledge is not always applied accurately, as a person’s conscience tells them how to apply this infallible knowledge, and this can go awry due to ignorance (Aquinas, 1225-1274).

The Christian reformer John Calvin understood conscience as knowledge plus a sense of the divine justice (Calvin, 1845). Indeed, the Catechism of the Catholic Church (1993) reflect this sentiment describing that one's conscience recognises and perceives guidance set out by divine law. Additionally, Islam teaches individual responsibility and accountability before an omniscient and equitable judge (Esposito, 1991). Finally, the Rabbi Abraham Joshua Heschel states that within Judaism:

"God is *He to whom we are accountable … He to whom our conscience is open…* We are exposed to the challenge of a power that, not both of our will nor installed by us, robs us of independence by its judgement of the rectitude or depravity of our actions, by its gnawing at our heart when we offend against its injunctions…" (Heschel, 1955, p. 158).

However, even within religious groups, there is frequent disagreement over moral questions. This means that even if a divine law that can be accessed through one's conscience exists, individuals disagree on its content (Brock, 2008). Consequently, it can be argued that as conscience is a witness rather than a direct source of knowledge from God, it can often be erroneous and fallible (Giubilini, 2016). However, Morton and Kirkwood (2009) comment that conscience is not unique to religious individuals, and although the content of the conscience of secular and religious individuals may differ, the mechanisms of conscience remain consistent. Thus, religious explanations of conscience are often considered outdated and incomplete, as they do not offer any explanation as to the formation of conscience among secular individuals (Greenawalt, 2010).

Conversely, the development of conscience in both secular and religious individuals can be understood as the product of internalising societal and parental norms and values. This conception is predicated on the belief that humans are influenced by society and are not born equipped with a conscience that deems certain types of behaviour immoral. Conscience can thus be described as a collective law, enforced by the fact that individuals are weaker than the power of the social group to which they belong. According to Paul (2015) our conscience is the voice of society within us, and culture is the medium conveying that voice. Paul (2015) adopts a traditional moral development standpoint that portrays young children in conscience-developing stages as reliant on externalised (rather than internalised) controls such as rewards and sanctions from authority. This is not dissimilar to Freud's (1935) understanding of conscience development, as he claimed that morality – which can be understood as part of one's conscience – is derived from the child's internalisation of parental values, as children have a strong emotional dependency on and identification with their parents. Learning theorists such as Bandura (1991) and Skinner (1971) also portray the development of conscience as a behaviour learnt from one's parents until better self-regulatory capacities develop. Similarly, cognitive-development theorists claim that young children are egocentric and consequentialist in their moral judgements, and obedience-orientated in understanding rules (Kohlberg, 1969; Piaget, 1974). Thus, for such theorists, conscience develops in young children through the socialisation of parental and societal norms and values, with little questioning from the children themselves.

However, such theories have been challenged as they downplay children's conceptual and emotional capabilities (Thompson, 2014). Alternative theories still work within the same framework as they posit that conscience develops through socialisation, but they challenge the stance that children are empty vessels. For example, social domain theorists argue that young children use multifaceted conceptual criteria to distinguish between social rules and relationships in different areas of social interaction (Killen et al., 2002; Smetana, 1997; Turiel, 2002). This is supported by the growth in literature on children's developing theory of mind (Harris, 1995) and the emotional and empathic origins of children's pro-social motivation (Eisenberg & Fabes, 1998). Aronfreed (1968) presents and alternative theory and posits that the notion of one's conscience developing through socialisation alone is too broad. Instead, he argues that "we might restrict the province of conscience to those areas of conduct where social experience has attached substantial affective value to the child's cognitive representation and evaluation of its own behaviour" (Aronfreed, 1968, p. 6). Thus, both theories work within the framework that deems socialisation the driver for developing one's conscience, but some scholars place more onus on the capabilities of the child when their conscience develops.

By contrast, conscience can also be understood as an expression of integrity. This stance has been widely accepted within academia (Antommaria, 2010). Such definitions infer that an individual's conscience can be understood as a mechanism for passing judgement on their actions or inactions. For Fuss (1964), conscience is the act of someone making reasoned judgements about moral questions, he emphasises that failing to adhere to one's conscience results in an emotional response. Examples of such responses include feelings of guilt, inner failure, and frustration. Similarly, Wicclair (2011) refers to emotional responses as 'moral distress', making an important distinction between pervasive 'every-day' moral distress and extreme moral distress caused by acting against one's conscience. Thus, individuals are predisposed to act in accordance with their beliefs and emotional responses when following their conscience.

Childress (1979) agrees that guilt can act as a motivator to prevent individuals making future unethical decisions and that conscience motivates a person to act according to their beliefs or moral principles. He further comments that personal identity is intimately related to the notion of conscience, as it encapsulates our sense of who we are and what characterises our individuality. He explains:

"[i]n appealing to conscience, I indicate that I am trying to preserve a sense of myself, my wholeness and integrity, my good conscience, and that I cannot preserve these qualities if I submit to certain requirements of the state or society" (Childress, 1979, p. 327).

For Childress, both integrity and sense of self are integral to the notion of conscience. Sulmasy (2008), however, believes conscience arises from an intention and commitment to be moral, asserting that:

"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" (Sulmasy, 2008, p. 2).

For Sulmasy, conscience involves acting on our understandings of what morality demands of us, while autonomously acting in accordance with what we consider morally preferable.

Defining conscience is important as it allows us to debate how it should be acted upon, and if or how it should be protected in healthcare. It is essential that a 'correct' definition is sourced to prevent complications arising in such debates (Lamb, 2016). However, it seems that it is impossible to reach an agreed definition of conscience, as reflected in the academic literature. This raises the key question: can we ever reach a 'correct' definition? For this reason, I combined the main principles of the conceptions of conscience that focus on integrity, as this is the most accepted position within the academic literature. I therefore define conscience for the purpose of my programme of research as:

A mechanism for passing judgment on one's actions and inactions that is largely fuelled by emotional responses, a commitment to be moral, and to preserve one's personal identity and integrity.

Why Strive to Preserve Conscience in Healthcare?

Ethicists and philisophers have deliberated over whether conscience should be protected in healthcare. Wicclair (2011) argues that it is imperative to protect conscience, and thus moral integrity, within healthcare. He contends that moral integrity should be protected on the basis that conscience can be an essential component in a person's quality and enjoyment of life, as betraying one's moral integrity can result in emotional responses such as guilt, remorse, shame, loss of identity, and a decline in moral character. If healthcare professionals have to forsake their ethics in one area of healthcare, it could result in them not applying ethical reasoning to other essential areas, thus impacting on the welfare of service users (Birchley, 2012; Burke, 2009; Wicclair, 2011). However, it is argued that healthcare professionals should not enter the health service if their moral integrity will be compromised by providing abortion care (Arthur et al., 2017). This is perhaps a simplistic approach that does not permit case-by-case objections, acknowledge changes in an individual's conscience due to personal and professional experiences (Lyus, 2017; Smith, 2018), or support the idea that healthcare is inextricably affected by one's conscience (Neal & Fovargue, 2016).

Moreover, the case is presented for encouraging moral integrity in the health service as it has intrinsic worth and value. Having core moral beliefs that mean an individual acts in accordance with their conscience (assuming it is ethically acceptable) can have desirable ends (Neal & Fovargue, 2019). Yet this theory is flawed for one important reason, as those who act in accordance with their conscience and protect their moral integrity may not have any objection. Following their conscience would provide the benefits Wicclair (2011) mentions without impacting upon service users' rights. Wicclair further asserts that we should aim for pluralism and cultural and moral diversity in the health service, as this is a principle of democratic, post-industrial societies. This is also endorsed by Baker (2009). Thus, it is inevitable that some of these professionals will object.

Wicclair (2011) also feels it is important to apply ethical epistemic modesty – the view that although ethical beliefs can be justified and unjustified and seen as correct or incorrect, we may be mistaken when labelling an ethical belief as correct or justified. Due to the contentious nature of abortion, it is an ethical issue around which society is less certain. The notion of ethical epistemic modesty has been described as fitting within a liberal democracy (Ben-Moshe, 2019). Some may argue that healthcare professionals and the public who disagree with abortion should aim to change the law, but act in accordance with it until such change is enacted. However, this stance is problematic, as healthcare professionals who object may understand the need for abortion but feel unable to provide the service themselves.

Finally, removing the right to object could result in staff shortages by discouraging entry to certain healthcare professions (Rodger & Blackshaw, 2020). For example, Sweden has a shortage of midwives (Hildingsson & Fenwick, 2015). This has been directly linked to the fact that conscientious objection is not protected as a legal right (Rodger & Blackshaw, 2020). This has impacted not only those seeking abortion services, but also those accessing maternity care. In some cases, those giving birth have had to travel up to 200 km due to the closure of maternity units (Holt, 2018, cited in Blackshaw & Rodger, 2020). Thus, the ethical and philosophical literature presents a strong case for allowing conscientious objection in healthcare. However, the potential impact it may have on service users is paramount and must be mitigated if conscientious objection is to remain within healthcare. The impact on service users inevitably varies from country to country but cannot be confirmed without empirical evidence.

Reasons Why Healthcare Practitioners Conscientiously Object

Religion and Conscientious Objection

A large proportion of the ethical and philosophical literature and research evidence on conscientious objection makes a connection with religious belief, stating that the conscientious objection clause protects religious freedom, as well as freedom of conscience (Meaney et al., 2012; Minerva, 2015; Nejaime & Siegel, 2015; Pellegrino, 2002; Savulescu, 2006). Forming such a connection is understandable, as some of the core beliefs of major religions prohibit abortion, or only allow it in certain circumstances (Hoffmann & Johnson, 2005). In the following section I review studies and essays on healthcare professionals' perspectives and views, which draw upon religion.

Religion is labelled a reason why healthcare professionals' object. Both Fleming et al. (2018) and Davis et al. (2022) discovered this when conducting systematic reviews that compiled empirical research. However, moral, and practical reasons were mentioned in the nursing and midwifery literature more frequently than religious ones (Fleming et al., 2018).

Both Pellegrino (2002) and Minerva (2015) focused on Roman Catholic objectors in their ethical deliberations of conscientious objection. Minerva (2017) claims that the high level of conscientious objection in Italy (between 69.6 and 90% of gynaecologists) can be explained by religious context, as Italy has a long tradition of Roman Catholicism. Similarly, Pellegrino (2002) states that Roman Catholic, Jewish, Protestant and Muslim healthcare professionals may hold beliefs that clash with medical law, thus compromising their moral integrity. He believes this dilemma is most acute for those with strong religious beliefs. It is understandable that religion was highlighted as a reason for conscientious objection, as only religious healthcare professionals were selected to participate in the research. This could mean an inaccurate representation has been presented, although Pellegrino is transparent about writing from a Catholic perspective.

Furthermore, it is important to acknowledge institutional conscientious objection in countries such as the US where whole institutions with a commitment to religious principles are able to object (Wicclair, 2011). Thus, it is apparent that there is a focus on religion fuelling conscientious objection within the literature.

Moreover, religion has been highlighted as a key reason for objecting in empirical research investigating healthcare professionals' views using both qualitative and quantitative research methods (Darzé & Júnior, 2018; Fink et al., 2016; Freeman & Coast, 2019; Lawrence & Curlin, 2009; Madeiro et al., 2016; Nordberg et al., 2014; Nordstrand et al., 2014; Toro-Flores et al., 2019). In table 3 I summarise quantitative empirical research that focuses upon religion as a reason for objecting.

Table 3: Quantitative studies that focus upon religion as a reason for objecting

Author	Country	Research Method	Sample Size	Participants	Conclusions Drawn
Lawrence and Curlin (2009)	United States of America	Postal Questionnaire	446	Physicians	Religious intensity was the strongest indicator for believing that physicians should never be obligated

					to do something with which they personally disagree.
Nordstrand et al. (2014)	Norway	Online Questionnaire	531	Medical Students	Students for whom religion was important were more likely to support conscientious objection.
Toro-flores et al. (2019)	Spain	Questionnaire	421	Nurses	Religious nurses were 6.12 times more likely to object than non-religious nurses.
Maderio et al. (2016)	Brazil	Online Questionnaire	1,174	Medical Students	Religion was the only characteristic associated with refusal to terminate.
Darzé and Júnior (2018)	Brazil	Questionnaire	120	Medical Students	Correlation between higher levels of reported religiosity, worship attendance, and conscientious objection.
French et al. (2016)	Nebraska US	Postal Survey	501	Physicians, Nurse Practitioners,	Religious clinicians were less likely to see referral as an

and Physician Assistants	obligation and less likely to refer service users themselves.

Thus, quantitative findings indicate that healthcare professionals who are religious are more likely to support conscientious objection or object themselves. However, although there is a clear correlation between religiosity and conscientious objection, it is important that we do not label this as causation, as there may be other reasons (extraneous variables) for healthcare professionals' objections. The studies I presented in the table have similar limitations; all relied on data collected through self-report surveys (which are an imperfect measure of actual beliefs and practices) and reported low response rates. None of the surveys were carried out in Britain or NI, so I could not extrapolate the findings to the UK context.

Notably, qualitative findings also support the claim that healthcare professionals object for religious reasons. For instance, both Norwegian (Nordberg et al., 2014) and Zambian (Freeman and Coast, 2019) empirical research discovered that Christianity lay at the heart of people's objections. However, Fink et al. (2016) reported that in Bogatá, Columbia 'partial objectors' who chose to object on a case-by-case basis did not discuss religion when expressing their reasons for objecting. By contrast, 'extreme objectors' (those who refused to refer, as well as perform terminations) spoke about their religious belief at length when explaining why they objected. Nevertheless, Velez and Urbano (2016) argue that the partial objectors in Fink et al.'s (2016) study were not protecting their conscience by objecting but were objecting for non-conscientious reasons. Thus, Fink et al.'s findings support a religious basis for conscientious objection. However, they used a small unrepresentative sample, as did Nordberg et al. (2014). By contrast, Freeman and Coast (2019) recruited a diverse demographic. However, none of the studies shed light on the context of the UK. Moreover, although a case can be made for a religious basis for conscientious objection, it is by no means the only reason why healthcare professionals object. In the following section I examine secular reasons why healthcare professionals may object.

Secular Conscientious Objection

Fleming et al's (2018) literature review and Czarnecki et al's (2019) qualitative study can be used to make the case for the link between religion and conscientious objection, but they also indicate that moral and practical reasons are important when understanding why healthcare professionals object. This is supported by Savulescu (2006) who philosophises that "[o]ther values can be as closely held and as central to conceptions of the good life as religious values" (p. 295). Moreover, Campbell (2011) actively challenges the relationship between religion and conscientious objection in his commentary, stating that not all objections are based on religious belief and that large numbers of religious healthcare professionals do not reflect a desire to accommodate religious conscientious objection.

Secular claims fit within the concept of conscience that I proffer within this programme of research. This is because conscience can be understood as a mechanism for passing judgment on one's actions and inactions that is largely fuelled by emotional responses and a commitment to be moral and to preserve personal identity and integrity. Emotional responses, moral guidelines and personal identity can be derived from a secular, as well as a religious origin (Adenitire, 2019; Brock, 2008; Dickens, 2014; Morton & Kirkwood, 2009). When objectors are protecting their conscience, they may be doing so on secular grounds. This is understood in British and Northern Irish law, as there is no stipulation that prevents secular objection; instead, in British law it merely 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" (Abortion Act, 1967). Because a religious affiliation does not have to be proven in order to object, there does not seem to be any form of discrimination towards secular objectors (Adenitire, 2019; Campbell, 2011).

Empirical evidence supports these claims, as although I have discussed religion as a reason for healthcare professionals' objections in the preceding section, studies have identified secular reasons for conscientious objection. For instance, Davis et al.'s (2012) study of 1144 registered nurses in Idaho (US) found that one third of the sample claimed their work and/or life experience was the most important influence in the development of their ethical beliefs, closely followed by religion. It should be noted that the study comprised both objectors and non-objectors, indicating that its relevance may be limited. Moreover, when surveying 733 medical students in Britain Strickland (2012) explored whether people’s reasons for objecting were religious or non-religious. Overall, 44.1% reported non-religious reasons, 19.7% reported religious reasons and 36.2% reported both religious and non-religious reasons. Thus, it seems there is a secular basis to some claims of conscientious objection. Although Strickland did not proceed to investigate what these reasons were, she did comment that it is perhaps too easy to conflate conscientious objection with religious beliefs.

Objecting on Non-Conscientious Grounds

Conscience-based refusals are distinguishable from those that are derived from other reasons. Such claims cannot be labelled as conscientious objection, as they do not impinge on the moral integrity of healthcare professionals, or if they do, it is not to a great extent (Hughes, 2018). Academics have propounded that conscientious objection should be regulated to prevent false claims. False claims of conscientious objection may be based on self-interest, considerations of professional integrity, stigma, views of civic affairs, discrimination, and lack of legal knowledge.

Objections arising from self-interest may stem from: concerns over one’s own well-being, financial gain, a need to reduce one’s workload, and the desire to have a more diverse workload. Healthcare professionals providing abortion care may encounter members of the anti-abortion movement who make unjust comments and act violently towards abortion caregivers, putting healthcare professionals and their loved ones at risk. The assassination of Dr George Teller by an anti-abortion extremist highlights the potential danger of offering abortion care (Gettig, 2009). Thus, it is understandable why (particularly in the context of the US) healthcare professionals may hesitate to offer abortion as a measure to protect themselves and their loved ones. This highlights one of many reasons for tighter restrictions around anti-abortion activism, to protect healthcare professionals as well as service users.

Moreover, such abuse can stem from the sociocultural environment and community stigma. This can influence whether healthcare professionals choose to object, as literature reviews of the empirical research indicate (Davis et al., 2022). Multiple objectors who took part in empirical studies based in Ghana (Awoonor-Williams et al., 2018), Brazil (Diniz et al., 2014), and Columbia (Harris et al., 2016) have commented that they chose to object because of community stigma. The Brazilian physicians in Diniz et al.'s (2014) study commented that they chose to object because the moral environment of illegal abortion imposed ambiguous feelings upon them such as stigma, shame, and fear. Consequently, physicians passed judgement on service users instead of listening to them. This resulted in objections based on stigma that were designed to prevent professional dishonour rather than protect one’s conscience.

Also, the conditions under which healthcare professionals work may improve by objecting; this could be financial, as healthcare professionals may receive more pay for providing other forms of care, as depicted by Meyers & Woods (1996) in their ethical essay. Harries et al. (2014) discovered the impact of monetary gain on conscientious objection when they found that clinicians in South Africa who objected were willing to perform abortions when financial incentives were given. However, Cowley (2016a) responds with the plausible argument that it is unlikely this would occur in a state-funded health system such as the NHS. Nevertheless, objecting could mean a reduced workload, as work is allocated to other members of staff who do not object, thus objectors could be avoiding an excessive workload and burnout (Boama, 2018; Contreras et al., 2011). Similarly, objecting could also mean a more interesting and diverse workload (depending on the number of objectors), as the bulk of non-objectors’ time may be spent performing abortions (Wicclair, 2011).

Furthermore, healthcare professionals may object to performing abortions on grounds of professional integrity rather than conscience. These refusals are grounded in professional norms and standards – or a healthcare professional's understanding of them. For example, such a professional may refuse to participate in abortion as they do not believe it is in the service user's best interest (Wicclair, 2011). Similarly, they may also object if they are misinformed and believe abortion will put a service user in unnecessary danger (Wicclair, 2011).

Healthcare professionals could object to providing abortion care to specific service users based on prejudice or views on civic affairs. They may therefore object to some abortions, but not others, on a case-by-case basis (Deans, 2016). This does not imply that all case-by-case decisions are discriminatory. However, in a parallel setting, findings have revealed prejudice in distributing birth control based on a service user's marital status in Canada (Glauser, 2014) and their social background in the UK (Cooper et al., 2008). Moreover, Alegre (2019) proposes a connection between the influence of religious values on civic affairs and conscientious objection, through the creation of a philosophical model. Objections may be based on religious views on abortion rather than an attempt to protect one's conscience. Thus, it is evident that healthcare professionals may object for reasons other than protecting their conscience, and these cannot be classed as conscientious objections. Yet the extent to which this happens is downplayed by Cowley (2016a) who does not deem this to be problematic in Britain, yet offers no empirical evidence to support this claim.

Finally, healthcare professionals or institutions may object due to lack of knowledge surrounding abortion-related laws and fear of legal persecution or problems related to abortion service provision (Küng et al., 2021). It has been acknowledged that this misuse of conscientious objection has occurred in Mexico and Bolivia (Küng et al., 2021) and healthcare professionals in NI did not pass on information to service users for fear of persecution before legalisation (Gentleman, 2017).

The majority of discussions around objecting on non-conscientious grounds assume such objections are problematic. However, Ancell and Sinnott-Armstrong (2017) take the opposite view and argue that these objections should be allowed based on a market view of conscientious objection. They contend that doctors possess the freedom to determine the scope of their practice, and correspondingly have the freedom to object, even on discriminatory grounds. They make the comparison between two objecting doctors: one who believes individuals should have access to abortion, but objects because they wish to avoid the costs and risks of providing abortion care, and another who objects because they believe abortion is murder and morally wrong. Ancell and Sinnott-Armstrong argue that both objections should be accepted as they fall within the range of the freedom in which doctors must define the scope of their practices. The scholars proceed to support discriminatory objections (although they acknowledge they are unjust) on the grounds that healthcare professionals who must give this care, but do not wish to will provide inadequate services. Instead, they propose a system where institutions publicly announce that they do not provide certain procedures for a particular population of service users. The institution is then required to inform and refer the service user and pay any costs they may incur. The purpose of the financial element is to act as a deterrent to decrease the number of discriminatory objections. This approach has been met with hostility, as Card (2019) contends that this is an abuse of power which does not respect the service user as they are not told why they have been refused. Consequently, there is no way of ensuring that the service user has access to the services to which they are entitled, and the market may not be able to bear mass objections of this manner. Moreover, this approach encourages doctors to do what is best for themselves and their institution, as well as to focus upon economic and business considerations rather than the service user's well-being.

Wicclair's Three-Part Ethical Framework

In this section, I discuss the literature around Wicclair's (2011) three-part ethical framework. I used this theory to inform the research aims, interview questions, and analysis of my data, thus, it was integral to my programme of research. Wicclair (2011) presents his theory as a three point framework comprising conscience absolutism, incompatibility thesis, and compromise (what I refer to as ‘the middle-ground’ to avoid loaded language). In the following sections I delve more deeply into these perspectives and explore the reasoning for these beliefs using ethical debates and empirical research.

The Incompatibility Thesis

The Ethics Behind the Incompatibility Thesis

Proponents of the incompatibility thesis believe that only those who are willing to offer all legal health services should enter healthcare. Savulescu (2006) makes this clear by stating that “[i]f people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.” (p. 294) The main reasons for these beliefs are the protection of service users’ reproductive and human rights, and the consequences and barriers of conscientious objection.

The service user’s right to access is seen as competing with the right of the healthcare professional to object. By objecting, such professionals are perceived to inevitably limit access and create barriers for service users (Fiala & Arthur, 2014, 2017a, 2017b; Giubilini, 2014, 2017; Johnson et al., 2013; Munthe, 2017; Savulescu & Schuklenk, 2017; Schuklenk, 2018; Schuklenk & Smalling, 2017). The World Health Organization (2022) supports the claim that conscientious objection is a major barrier for service users.

Furthermore, it has been argued that allowing conscientious objection can result in emotional distress for service users, and in extreme cases, unwanted pregnancy, harm, and even death to service users. Additional costs may arise because of the objection. For example, service users may become burdened with financial costs such as travel, day-care expenses, and time off work, disproportionally impacting those of low income and socio-economic status (Fiala & Arthur, 2014). It can be argued that financial responsibilities should not be the healthcare professional’s prerogative. If they were, healthcare professionals would not be able to take holidays and would work tireless hours and provide evening services (Wicclair, 2011). While this makes sense, it does not compensate for health-related costs, as objections can result in longer waiting times which can increase the medical risk of abortion and the type of abortion provided (Fiala & Arthur, 2014).

In addition, proponents of the incompatibility thesis argue that healthcare professionals do have the right to object, as well as having the freedom to exercise autonomy. This right presents itself when they are deciding whether to go into healthcare, and which area to enter (Munthe, 2017). However, this becomes somewhat problematic with the changing role of midwives and other healthcare professionals, as they may now have to offer abortion services that they did not have to offer when entering the profession (Kishen & Stedman, 2010). This has been considered and rejected as an insufficient reason to remove service users' right to access, as it is argued that services change and healthcare professionals should change with them or exit that area of healthcare, as service users' human rights and right to access take precedence (Schuklenk, 2018).

Furthermore, it is argued that healthcare professionals have an obligation to provide all legal services, and personal ideological convictions should not be placed above this (Savulescu, 2006; Schuklenk, 2018; Schuklenk & Smalling, 2017). Rhodes (2006) argues that entering a role in healthcare is synonymous with entering a contract with society. A high degree of self-governance and a monopoly of knowledge and service provision is supplied by society; therefore, healthcare professionals should respect this by offering all the legal services they are trained to provide. Rhodes summarises this as follows:

"First […] clinician decisions must be informed by professional judgement, not personal judgement. Patients and society rely on physicians to provide treatment according to that standard ... The second implication is that becoming a doctor is a moral commitment to give priority to 'the ethical standard of care' over personal values. Becoming a doctor is, therefore, also ceding authority to professional judgement over personal preference" (Rhodes, 2006, p. 78).

Moreover, 70% of UK medical schools embrace a variation of the Hippocratic Oath (Green, 2017). The original Hippocratic Oath focused on saving human lives. More recent revisions state that doctors not only save lives, they also have the power to take lives, but should not play God with this power (Lasagna, 1964). These revisions fit with the incompatibility thesis approach, as proponents of the incompatibility thesis (Wicclair, 2011) argue that not all professional values are consistent with the aim of saving lives, and that this principle has eroded and been replaced with serving health, an undisputed and uncontroversial principle of medicine. It has also been argued that doctors must provide abortion care to act in accordance with serving patients' health and should not be able to object to participating in abortion (Giubilini, 2017).

In addition, disallowing conscientious objection can be understood from an approach that focuses on morality. Bhakuni and Miotto (2021) present this belief when making the correspondence argument. This argument works on the premise that when abortion is a morally justified act, objections that prevent service users from accessing it, or create additional burdens are morally unjustified. Thus, Bhakuni and Miotto argue that conscientious objection should be disallowed as a matter of public health policy in the Global South, even when referral services are possible. This approach has been applied to developing countries, although Bhakuni and Miotto contend that it could be extended to the developed world as, regardless of the systematic inadequacy of healthcare resources within that geographic areas, conscientious objection can pose burdens on those seeking abortion in developed countries such as Italy.

Finally, the term 'conscientious objection' is criticised by supporters of the incompatibility thesis, they replace it with the phrase 'dishonourable disobedience'. This reiterates the stance that conscientious objection is unworkable, inappropriate, unethical, and unprofessional (Fiala & Arthur, 2014). Fiala and Arthur (2014) state that "conscientious objection should more aptly be called 'dishonourable disobedience' because it violates women's fundamental right to lawful healthcare and places the entire burden of consequences, including risks to health and life, on the shoulders of women" (p.18). By the same token, conscientious objection is labelled a form of 'structural violence' and a control device that acts as a barrier limiting the pregnant person's access to legal abortion, infringing upon their dignity, contravening their autonomy, and exposing their life and health to harm (Montero et al., 2022).

Healthcare Professionals Support of the Incompatibility Thesis

Research suggests that the incompatibility thesis is supported by healthcare professionals in certain contexts. For instance, only 34.2% of medical professionals and 21.4% of nursing professionals in a Finnish study (n=548) (Nieminen et al., 2015) believed healthcare professionals should have the right to conscientiously object. This could reflect the context of abortion in Finland as there are no conscientious objection clauses in healthcare legislation in the Finnish healthcare system. However, the study produced mixed findings regarding perceptions of conscientious objection, as questions were asked that reflected the real-life complexities of conscientious objection such as gestation time and the role of healthcare professionals (Nieminen et al., 2015). Moreover, findings from Argentina revealed that 70% of participants (general practitioners, ob-gyn or surgical gynaecologists, nurses, social workers, and psychologists) (n = 269) believed that conscientious objection to abortion leads to a breach of professional duties, with only 7% stating that it is a fundamental human right (Michel et al., 2020).

The Incompatibility Thesis in Practice

Very few countries embrace the incompatibility thesis approach and disallow conscientious objection. However, Sweden and Finland are examples of countries that do not support conscientious objection to abortion as a legal right. In Sweden there is no conscience clause in the abortion act, and in Finland conscientious objection is legally outlawed in the act (Fiala et al., 2016). These measures have been take to protect service users.

On the other hand, in Britain barriers to access are often labelled a mere inconvenience as it is assumed that there are low numbers of objectors and that there will always be a healthcare professional who can take over (Cowley, 2016a). However, proponents of the incompatibility thesis (Wicclair, 2011) would argue it cannot be assumed that service users are able to access the healthcare they require, and that this problem should be mitigated by the removal of conscientious objection from healthcare. This is especially problematic in rural areas and is increasingly problematic when considering the social context, and the predicted high number of objectors in NI (Emmerich, 2020).

Furthemore, In countries that allow conscientious objection, barriers to access are heightened in areas which have high levels of conscientious objection. For instance, “In 2016, 71% of Italian gynecologists – even more than 85% in some regions – were objectors, and only 60% of hospitals with an obstetrics and gynecologists ward offered abortions” (Autorino et al., 2020, p. 1). This demonstrates an obvious barrier to access, which has been disputed by the Italian Committee for Bioethics who argue that there is ‘no correlation’ between conscientious objection and waiting times for abortion in Italy. However, the ‘no correlation’ argument has been challenged, with calls for further studies on the impact of conscientious objection on service users in Italy (Bo et al., 2017).

Also, those residing in rural areas with low staff numbers are more likely to experience conscientious objection, especially those in areas where abortion is a contentious subject, as there are often high numbers of objectors (Heino et al., 2013). Thus, it has been argued by those of the incompatibility thesis perspective that conscientious objection unfairly disadvantages certain members of society and prevents the implementation of an equitable and fair health service.

Conscience Absolutism

The Ethics Behind Conscience Absolutism

In opposition to the incompatibility thesis, advocates of conscience absolutism believe that healthcare professionals should not only have the right to conscientious objection, but also the right to refrain from participating in any care they wish, including giving information on abortion and referring patients to non-objecting healthcare professionals.

This argument is based upon morality, complicity, and accountability and can be understood by unpicking the doctrine of double effect (DDE) (Purcell et al., 2014).

Firstly, it is argued that healthcare professionals who refer and give information to service users are endorsing the act to which they object, as it can be argued that referral and informing equates to approval and recommendation (Cavanaugh, 2010). However, in the case of informing service users, advocates of the middle-ground approach argue that a sense of approval and recommendation can be mitigated by healthcare professionals explaining in a sensitive manner that they do not agree with abortion on moral grounds (Cowley, 2017). Conscience absolutists disagree, as although they present their stance, it does not remove moral complicity as they are an integral link in the chain of events. Karen Brauer, President of Pharmacists for life, shares this view when she states that facilitating referral of a service user "is like saying, I don't kill people myself, but let me tell you about the guy down the street who does" (Brauer, cited in Minerva, 2017, p. 111). Thus, from this standpoint, healthcare professionals are accountable as accomplices, which impacts upon their conscience and morally undermines the conscientious objection clause (Fink et al., 2016; Jones-Nosacek, 2022; Trigg, 2017).

Furthermore, from a Roman Catholic perspective, complicity in the form of giving information or referring is morally wrong. Oderberg (2017) presents a refined account of the DDE (Purcell et al., 2014) – an ethical device derived from St. Thomas Aquinas' justification of killing in self-defence – to make sense of co-operation, claiming giving information/a referral is a material contribution that makes healthcare professionals morally complicit. This means the DDE would support conscience absolutism, unless the contribution can be proven to be not sufficiently proximate, indispensable, or disproportionate.

Conversely, it is argued that healthcare professionals may refuse to refer, not because of self-interest, but because they believe continuing the pregnancy is the best course of action for the service user (Jones-Nosacek, 2022). In so doing, these professionals may believe that they are adhering to their fiduciary duty to act in the service user's best interest, regardless of whether this is supported by the service user (Jones-Nosacek, 2022).

Moreover, it is argued that healthcare professionals should not have to be involved, to a greater or lesser extent, in something they believe is morally wrong as this goes against the principles of liberal democracy (Trigg, 2017). Furthermore, although Wicclair (2011) advocates the middle-ground approach, he concludes after ethical deliberation that deference should be given to healthcare professionals' perceptions of moral complicity as their conceptions may not fit any given criteria, but nonetheless should be protected. If the goal is to protect moral integrity, healthcare professionals' moral beliefs about complicity should be taken into consideration.

Healthcare Professionals' Support for Conscience Absolutism

Empirical research sheds light upon the conscience absolutist perspective. Curlin et al.'s (2007) US-based study of 2000 US doctors concluded that 'several' doctors did not consider themselves obliged to inform and refer patients for morally controversial but legal procedures. Similarly, Combs et al.'s (2011) study of 1032 US doctors revealed that 44% of participants disagreed or strongly disagreed that doctors have a professional obligation to refer if they believe such referral is immoral. Thus, both studies highlight the conscientious absolutist perspective in the US. Regrettably, Strickland's (2012) British study did not elicit participants' beliefs on informing and referring service users, a limitation that could have helped gain insight into conscience absolutism in Britain.

Conscience Absolutism in Practice

It is unlikely that conscience absolutism would be effective in practice within the UK, as despite the wealth of online information, service users are often dependent on healthcare professionals for reliable information (McLeod, 2008; Newman, 2013; Wicclair, 2011). For example, there is a plethora of websites selling fake abortion pills online under the name of reputable organisations such as Women on Waves (Women on Waves Group, n.d.). Service users may opt for this as an easy option, or what they consider to be their only option, which unnecessarily puts their health at risk. However, there is a weak argument that lacks empirical evidence which states that service users can still access abortion easily, even when healthcare professionals do not give information or refer

(Cowley, 2017). In fact, some empirical evidence infers that service users rely on healthcare professionals to access abortion (Harden & Ogden, 1999; Lie et al., 2008) and those who have accessed abortion via self-referral have commented that public awareness on how to self-refer for an abortion needs to be increased (Low et al., 2020).

Minerva (2017) adopts a practical approach to explain how conscience absolutism can be accommodated using a ‘ratio approach’. She explains that healthcare professionals would be allocated to a specific geographical radius to ensure there is a 50:50 (or whatever ratio empirical research deems fit) split of objectors to non-objectors. She continues to explain that objectors would not have to encounter service users seeking an abortion, as information could be displayed noting their objection and reception staff could give patients information on abortion. However, this unequivocally undermines any objections reception staff may have, and could result in numerous healthcare professionals having to relocate. It would also be a lengthy and costly process to implement. Rodger and Blackshaw's (2020) development of Minerva’s ratio approach has similar shortcomings, although it would be less costly to undertake. They propose a quota approach is implemented at the training admission stage; in countries where conscientious objection has been shown to have an impact on service provision, or where conscientious objection is currently not permitted, which may be beneficial in terms of alleviating staffing pressures. Likewise, as Minerva does, they suggest that quotas may have to be put in place in certain geographic areas to ensure service provision. Thus, it could be argued that conscience absolutism makes sense ethically, although changes could be costly and disruptive to current healthcare professionals.

Compromise (Middle-Ground)

The Ethics Behind the Middle-Ground Approach

Conscientious objection appears to present a conflict between the rights of healthcare professionals and service users, as displayed by the incompatibility thesis and conscience absolutism (Wicclair, 2011). Advocates of the middle-ground approach strive to balance the right of healthcare professionals to preserve their moral integrity with the right of service users to access healthcare. This offers a holistic approach to balancing human rights (Bielefeldt, 2017). It is the most widely discussed and accepted stance within academia and in practice (Wester, 2015), with academics from a plethora of disciplines justifying why, and how, we should aim to compromise and balance these rights. Brock (2008) outlines what he refers to as the ‘conventional compromise’ which describes the premise of what I term the middle-ground approach:

“According to the conventional compromise, a physician/pharmacist who has a serious moral objection to providing a service/product to a patient/customer is not required to do so only if the following three conditions are satisfied:

1. The physician/pharmacist informs the patient/customer about the service/product if it is medically relevant to their medical condition;
2. The physician/pharmacist refers the patient/customer to another professional willing and able to provide the service/product;
3. The referral does not impose an unreasonable burden on the patient/customer” (Brock, 2008, p. 194).

There has been much discussion around moral complicity regarding giving information and referral. This is a contentious subject as some proponents of the middle-ground approach such as Wicclair (2011) admit that informing and referring may make healthcare professionals morally complicit if they see themselves as such. However, Cowley (2017) argues that context is key, as some healthcare professionals are more morally complicit than others. The distinguishing factor for Cowley is whether the service user exits the ‘space’ and enters the public sphere, as this gives the service user the freedom to reflect on the information they have been given and to decide whether they wish to proceed with the abortion. He argues that when service users visit their GP, they exit into the public space of the waiting room, whereas when visiting a nurse or midwife on a ward, service users tend not to re-enter the public sphere. He deems this the ‘confined patient trajectory’. Cowley's (2017) focus is solely on GPs in the NHS; thus, his stance on other healthcare professionals having to refer and inform is unclear, although he does state that it is not his intention to give a broad argument. Nevertheless, Cowley (2017) conflates giving information and referral when discussing moral complicity, explaining that in Britain there is a duty to refer as GPs must give the service users enough information to access an abortion. He therefore concludes that GPs working for the NHS have a duty to refer and inform service users and should not feel morally complicit by doing so. Nevertheless, this theory has been met with criticism on the grounds that Cowley misunderstands cooperation and moral complicity, and GPs may well feel morally complicit when informing and referring service users (Finegan, 2019).

Antommaria (2010) focuses on the remoteness of the action when discussing, informing, and referring service users. He argues that giving medically correct information is essential for the service user to make an informed decision. However, he asserts that providers are not morally complicit if they state that they believe the intervention is immoral without elaborating, unless requested. Brock (2008) takes the same stance regarding passing on information and moral complicity, although he argues that healthcare professionals should clarify why they take this stance, as this would result in relatively minimal moral complicity. It also means that service users understand that this particular professional has a moral objection, rather than a medical reason to disallow abortion.

Additionally, with respect to referral, Antommaria (2010) and Chervenak and McCullough (2008) distinguish between direct and indirect referral. A direct referral requires communicating with a non-objecting healthcare professional, while indirect referral requires the objector to give specific information as to where the abortion can be obtained. They state that there is an increase in moral complicity when a direct referral is made. The guidelines for doctors in the UK requires indirect referral (General Medical Council, 2020b).

However, it is argued that individuals who object, but work for an institution which provides abortion care are morally complicit as they accept work which frees the time of non-objecting healthcare professionals, allowing them to provide abortion care (Clarke, 2017). This principle can be applied to referring and informing service users. Clarke argues that healthcare professionals who are willing to work for institutions that provide abortions should feel no additional burden and moral complicity when referring patients. However, this argument is problematic as it could be extended to the whole NHS, rather than the local level of individual practice, which means objectors may not feel able to work for the NHS.

Moreover, as previously noted, some scholars assume that healthcare professionals have a professional obligation to provide care that may go against their conscience (Savulescu, 2006; Savulescu & Schuklenk, 2017). Alternatively, it is argued that informing and referring to another professional is an acceptable commitment to one's professional obligations. This is deemed appropriate, as not only does it protect the conscience and human rights of objectors and access for service users, but referral is already widely accepted in healthcare as specialist and subspecialists only offer a limited range of services (Wicclair, 2011).

Furthermore, the transnational network of physicians, Global Doctors for Choice support the claim that a healthcare professional's conscience can be respected while prioritising a service user's needs. They state:

> "As a physician group, we advocate for the rights of individual physicians to maintain their integrity by honouring their conscience. We simultaneously advocate that physicians maintain the integrity of the profession by according first priority to patient needs and to adherence to the highest standards of evidence-based care" (Chavkin, 2013, p. S39).

In summary, none of these considerations completely dismiss the presence of moral complicity in relation to referring and informing. Instead, they delineate the different extents to which individuals 'should' or 'should not' feel morally complicit, based on an ethical analysis. This excludes Wicclair's (2011) theory which holds that an individual's personal understandings of moral complicity should be respected, but the needs of the service user should be put first. This seems the most plausible argument, although implementing a middle-ground approach in practice seems incoherent as it undermines healthcare professionals' moral complicity in relation to informing and referring. Hughes

(2018) develops upon Wicclair's (2011) stance, arguing that we should adopt a practical approach by focusing on the views of healthcare professionals, and what they are willing to do to compromise, rather than on hypothetical and ethical debates.

Healthcare Professionals Views on the Middle-Ground Approach

Research indicates that the majority of non-objecting and objecting healthcare professionals support the middle-ground perspective, as the majority of participants in studies conducted in Chile (Biggs et al., 2020), the US, (Brauer et al., 2016; Combs et al., 2011; Curlin et al., 2007; Frank, 2011), Brazil (Darzé & Júnior 2018), and Norway (Nordstrand et al., 2014) believed that referring and informing service users is essential. However, all these studies have the following limitations: (i) they are all surveys with low response rates, which means that non-respondents' views may have differed in ways that biased the findings; (ii) none of the studies examined the heterogenous details of referral, as a referral can either be a healthcare professional transferring a patient's medical records to another provider, arranging an appointment at an abortion clinic/advisory service, or informing the service user of how to access abortion; (iii) moral complicity with regard to referring and informing service users was not questioned; thus, we do not know the respondents' views on this.

The Middle-Ground Approach in Practice

Research indicates that, in some contexts, the middle-ground approach is not working in practice. In Victoria, Australia abortion providers and experts reported that doctors had contravened the law in multiple ways, including claiming objections on non-conscientious grounds, not referring service users, attempting to delay service users' access, and striving to make service users feel guilty. These actions impacted service users by causing emotional distress, delays in accessing services, and by causing serious health consequences (Keogh et al., 2019). Such findings exemplify Tongue's (2022) argument that self-regulatory mechanisms do not work in practice in some contexts and regulation is necessary to ensure service users' human rights are maintained. I explore this further in the section titled 'regulation'.

Legal Perspectives on Conscientious Objection

The Right to Conscientious Objection and the Right to Healthcare

In the previous section, I outlined the ethical perspectives on conscientious objection. In the following section, I examine how conscience as a fundamental human right, and the right to abortion and healthcare are protected to varying degrees.

Legal Protections for Healthcare Practitioners

Though not legally binding, Article 18 of the 1948 Universal Declaration of Human Rights states that: "Everyone has the right to freedom of thought, conscience and religion; this right includes freedom . . . to manifest his religion or belief in teaching, practice, worship and observance." (United Nations, 1948, Article. 18). However, the International Covenant on Civil and Political Rights makes it clear that this right is not absolute, outlining in articles 18(3) that: "Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others" (United Nations, 1966, Article. 18(3)). Although a case can be made to disallow conscientious objection on the grounds of protecting public health and the fundamental rights and freedoms of others, British and Northern Irish abortion law quashes this argument as the fourth clause of the 1967 Abortion Act and the seventh of The Abortion (Northern Ireland) regulations protects healthcare professionals' freedom of conscience.

European treaties such as the 1763 Council of Europe's Resolution also support freedom of conscience (Parliamentary Assembly, 2010). This resolution highlights the need to balance the rights of healthcare professionals to object with the rights of service users to access healthcare. All European countries, excluding Sweden, have accepted the resolution – in Sweden, service users' rights are paramount (Crespigny et al., 2012). In fact, the European Court of Human Rights refused to adjudicate the case of *Grimmark and Steen*. The two applicants were employed as nurses within the Swedish healthcare system and were granted leave to study to become midwives. During their studies, the nurses informed their employers that they would not be able to provide abortion care. Both applicants were told that they could not work in women's clinics if they refused to participate in abortion. The applicants refused and as a result were not employed. The applicants approached the court, filing complaints under freedom of thought, conscience, and religion (Article 9 of the European Convention on Human Rights), freedom of expression (Article 10 of the European Convention on Human Rights), and protection from discrimination (Article 14 of the European Convention on Human Rights). Without adequate reasoning, the court rejected the cases as inadmissible (Brzozowski, 2021). This stance received severe criticism in academia, it is argued that more should have been done to protect the midwives' consciences (Brzozowski, 2021; Domenici, 2020).

The UK Human Rights Act 1998 (Article 9) takes a similar approach to the Universal Declaration of Human Rights and the European Declaration of Human Rights, stating that:

> "1. 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 worship, teaching, practice and observance.
>
> 2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or the protection of the rights and freedoms of others" (Human Rights Act, 1998, Article. 9).

Again, these rights are not absolute, as Article 9(2) limits them somewhat, repeating Article 18(3) of the International Covenant on Civil and Political Rights (Human Rights Act, 1998).

Notably, McHale recognised the shift from surgical to medical abortions and concluded that public policy should be revised accordingly, meaning nurses should not be permitted to opt out of abortion (Fleming et al., 2018). Thus, it is evident that the law strives to allow healthcare professionals to object on grounds of protecting their conscience, with most European countries complying.

Legal Protections for Service Users

Firstly, service users have a right to access healthcare, as outlined in Article 18(3) of the International Covenant on Civil and Political Rights and Article 9(2) of the Human Rights Act. However, these rights have been coined by some as rights *in* healthcare, rather than rights *to* healthcare (Brazier, 1993). Rights in healthcare include rights to: informed consent, bodily integrity, confidentiality, and non-negligent treatment (Campbell, 2011). Moreover, in the context of English law, abortion is essentially available on demand due to the liberal interpretation of the Abortion Act by doctors, yet it is not considered a legal right, as the act only decriminalises abortion when two doctors agree that the relevant criteria are met (Abortion Act, 1967). Nevertheless, it is argued that abortion is considered a right and is protected under human rights law in emergency situations when a service user's health or life is at risk, the pregnancy is a result of incest or rape, or there is a risk of foetal impairment. The grounds for these terminations are based upon the following human rights principles: a right to bodily integrity or freedom from inhuman treatment (in cases of rape, severe foetal abnormality, and incest), and the right to life and health (in cases where the abortion will save the pregnant person's life or protect their health) (Zampas & Gher, 2008). Thus, service users have no legal right to abortion care when the abortion is labelled a 'social abortion' (Zampas & Gher, 2008). Nevertheless, it is important to note that negligent behaviour from healthcare professionals that intentionally or carelessly obstructs access to abortion makes them legally liable for negligence (Campbell, 2011).

Despite this, the promotion of women's and individuals' who can become pregnant reproductive rights as human rights has gained momentum. Prior to this, rights to reproductive health and reproductive decision-making (including abortion) were marginalised within human rights discourse and ideology (Rebouché, 2016). Zampas and Gher (2008) argue that the advancement in reproductive rights is due to the 1994 International Conference on Population and Development and the 1995 Fourth World UN conference on Women, both of which led to the recognition that protecting sexual and reproductive health is an issue concerned with social justice, and that access to reproductive healthcare should be protected as a human right through existing national constitutions and human rights treaties. The conferences focused on unsafe abortion, labelling it a public health concern and the consequences a violation of human rights. These were the first human rights documents to explicitly refer to abortion. Though not legally binding, such documents are often used to support legislative and policy reform, as well as interpretations of international and national law (Zampas & Gher, 2008). Since 1995, international human rights documents have downplayed state autonomy over abortion and have emphasised safe and legal abortion as a human rights concern for all countries (Rebouché, 2016).

The case of Ireland has been used to exemplify how abortion as a human right has been protected and informed by international guidelines (Rebouché, 2016). In 2016, the United Nations Human Rights Committee, used the Optional Protocol of the International Covenant on Civil and Political Rights, to consider the impact of Ireland’s almost total abortion ban in the case of Amanda Mellet (UN Human Rights Treaty Bodies, 2016). Mellet was 21 weeks pregnant when she found out that her foetus had a fatal condition which would result in its death *in utero* or shortly after birth. Mellet was advised by her midwife and doctor that aborting the pregnancy was not an option in Ireland. Therefore, she travelled to Liverpool to access an abortion and incurred significant costs in doing so. Mellet believed that abortion was the best option as it would ‘spare her child suffering’. The United Nations Human Rights Committee deemed Mellet’s treatment a violation of the right to equal protection of the law (Article 26), to privacy (Article 17), and protection from cruel and unusual treatment (Article 7) under the International Covenant on Civil and Political Rights. As a result, it proposed (non-legally binding) that the state pay Mellet compensation and provide her with psychological treatment, as well as revising national legislation to ensure it would comply with the International Covenant on Civil and

Political Rights (UN Human Rights Treaty Bodies, 2016). Shortly after this, the eighth amendment was repealed following a constitutional referendum, lifting Ireland's near total ban on abortion and legalising it. This change in law was one of the facilitators of the change in NI's abortion law in 2019 (Calkin & Berny, 2021) and indicates how abortion fits within a human rights-based framework.

Thus, both the right to conscience and the right to abortion are not absolute rights and are often pitted against one another in the conscientious objection debate (Viggiani, 2019). However, it is argued that it is not conducive to do so as it is not a zero-sum game and the rights of service users can be ensured while allowing conscientious objection (Campbell, 2011).

Guidelines for Healthcare Professionals

All doctors in the UK are required by law to register with the GMC and midwifes and nurses with the NMC. It then becomes optional for them to join the following trade unions: BMA (doctors), RCM, and the RCN. Those who object are obligated to follow the guidelines issued by the regulatory bodies. These reinforce British and Northern Irish abortion law and present additional parameters which go unregulated. The GMC and the NMC support healthcare professionals who object if they treat patients fairly and with respect. However, they stipulate that services users' rights are paramount and take precedence over the right to object (General Medical Council, 2020a; Nursing and Midwifery Council, 2018). This stance has also been adopted by the BMA which states that "a doctor's primary obligation is his or her [(or their)] patient. Where a conflict arises between the interests of a patient and a doctor's freedom to exercise a conscientious objection to manifest belief, the conflict must be resolved in favour of the patient" (British Medical Association, 2020, p. 5). This has been reiterated by the other trade unions.

Paragraph 4.4 of the NMC Code states the following guidelines for midwives and nursing associates who wish to object: "tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure" (Nursing and

Midwifery Council, 2018, p. 18). It then advises such professionals to "make sure you do not express your personal beliefs (including political, religious or moral) to people in an inappropriate way" (Nursing and Midwifery Council, 2018, p. 18). Thus, the NMC believes there should be transparency around the objection and all parties should be aware that care is being transferred due to a conscientious objection, rather than for medical reasons. This should be translated in a professional manner without judgement. The RCN takes the same view, adding that dealing with an objection in this manner is essential for a successful therapeutic relationship (Royal College of Nursing, 2020).

This stance on transparency and judgement is reiterated in the GMC's Good Medical Practice, which states that "[y]ou [(the doctor)] must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs." (General Medical Council, 2020a, para. 52). Thus, for doctors to object, they must inform the service user of their objection without casting disapproval, and that they are able to see another doctor to discuss their options. This is reiterated in the BMA guidelines (British Medical Association, 2020).

By contrast, the NMC clarifies that it is the duty of the objecting nurse or midwife to refer the service user to a non-objecting colleague, as their Code states that objectors have a duty to "arrange for a suitably qualified colleague to take over responsibility for that person's care" (Nursing and Midwifery Council, 2018, p. 18). However, guidance on referring the service user is slightly more ambiguous in the GMC's Good Medical Practice, it states that "if it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role" (General Medical Council, 2020a, para 52). Thus, it seems that it is at the doctor's discretion whether they refer the service user to another colleague, or whether the service user must navigate setting up another appointment with a GP. Nevertheless, it notes that doctors "must not obstruct patients from accessing services or leave them with nowhere to turn" (General Medical Council, 2020b, para. 15).

Moreover, it is important to distinguish between a GP objecting and referring a service user to another GP who will take over their role, and a GP making a formal referral. When a GP makes a formal referral they sign the relevant bureaucratic form and the service user is formally transferred within the health service (Cowley, 2017).

The RCM stipulates that midwives are only able to object to "direct involvement in the procedure of terminating pregnancy" (The Royal College of Midwives, 2016, p. para 8). This is a similar stance to the RCN which instead lists what nurses cannot object to. They explain that nurses cannot object to providing care for a service user before or after the abortion, or in emergency situations (Royal College of Nursing, 2020). This guidance aligns with the Supreme Court's stance on participation in the Doogan and Wood case (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014). Similarly, the BMA states that "[t]he limits of conscientious objection in abortion were confirmed in the UK case of Janaway v Salford Area Health Authority (1988) UKHL 17 which held that the right is limited to a refusal to participate in the procedure(s) itself and not to pre- or post-treatment care, advice, or management" (British Medical Association, 2020, para 7), concluding that doctors can only object in non-emergency situations. Yet outlining the court case may create confusion, as it seems the BMA is presenting this as an example of what doctors can and cannot object to, but this contradicts the guidance that they give regarding how to object to completing the HSA1 documentation.

The GMC and the NMC provide guidance that is vaguer than that of the trade unions. The GMC merely comments that "[y]ou may choose to opt out of providing a particular procedure because of your personal beliefs and values" (General Medical Council, 2020b, p. 8). Similarly, the NMC does not explicitly outline what healthcare professionals are able to object to (Nursing and Midwifery Council, 2018). The lack of clarity from both councils perhaps reflects the contentious nature and lack of agreement over a clear definition of 'participating in abortion'.

Recent Shifts in Legislation in the UK

I previously noted that conscientious objection is enshrined as a right within the fourth clause of the 1967 Abortion Act, and the seventh of The Abortion (Northern Ireland) Regulations and many European and universal laws support conscientious objection. In the following section, I examine recent changes in abortion law in the UK and how these have/could impact upon conscientious objection. I discuss the shift in law in NI to legalise abortion, and the impact that COVID-19 has had on abortion law.

Historically, NI has adopted an anti-abortion stance, reflecting the impact that religious theology has on social, cultural, and political thought (Mitchell, 2013). NI's healthcare professionals and service users are not protected under the Abortion Act (1967) which exempts abortion from criminal sanction when authorised by two doctors in a defined set of circumstances. Instead, both parties were liable to prosecution under the Offences Against the Person Act 1861 (which is the same legal ruling in England and Wales). Individual doctors were therefore left to decide under threat of criminal prosecution whether service users should have access to abortion on the basis of potential physical or mental harm (Fegan & Rebouche, 2003). In 2018, 12 abortions were performed in NI (Griffin, 2019), reflecting how reluctant doctors were to allow abortion. The lack of access to abortion attracted widespread criticism domestically and internationally as an infringement of human rights, resulting in a shift in legislation in 2019 when abortion was decriminalised, setting NI ahead of other UK countries where abortion remains a criminal act in certain circumstances. The Abortion Act (1967) was not extended to NI, instead a *de novo* framework was introduced, although it has clearly been informed by the Abortion Act (1967). Specifically, the conscientious objection clause mirrors the Abortion Act (1967).

However, full commissioning of abortion services and post-abortion services in NI by the Northern Irish Department of Health has not happened. Healthcare professionals have to provide abortion care on an *ad hoc* basis with no funding or training (Rough, 2023). Therefore, service users still continue to travel to England for abortion services using BPAS's centralised booking service which now includes funding which is not means tested (Emmerich, 2020). This is reflected in the fact that only 63 abortions occurred in NI in 2020-21, whilst 371 pregnant individuals travelled to England to access an abortion (Rough, 2023).

This issue has been raised in Westminster and beyond. The NIHRC (Northern Ireland Human Rights Commission) has taken legal action against the Sectary of State for NI, as he failed to provide abortion and post-abortion care for pregnant individuals in public health facilities in NI. The NIHRC has also challenged the NI Minister of Health and Northern Ireland Executive Committee as they failed to agree to fund and commission abortion and post-abortion care in NI (Rough, 2023). Despite this, the Northern Irish Health Minister has stated that regulations do not compel the Northern Ireland Executive/Health and Social Care Board to provide abortion care. The NIHRC's claim for judicial review against the Northern Ireland Executive Committee and the Northern Irish Health Minister was dismissed (Rough, 2023).

In March 2021, the gaps in commissioning abortion services in NI were addressed by the UK Government. Approvals were granted in the Houses of Parliament in April 2021 that allowed the UK Secretary of State for NI to direct Northern Irish departments, ministers, and agencies to ensure that abortion services would be commissioned in NI (Rough, 2023). The Secretary of State aimed to make abortion services available in NI by the 31st of March 2022. However, a week before the deadline, he stated that the Northern Irish Department of Health would not be able to provide such services in NI by the deadline (Rough, 2023).

Subsequently, The Abortion (Northern Ireland) Regulations (2022) came into force on 19 May 2022. They gave the Northern Ireland Secretary the power to intervene directly to ensure abortion services were implemented. In addition, they place an obligation on the Northern Ireland Department of Health to provide and fund abortion and post-abortion services without discussions and approval from the Northern Ireland Executive Committee (Rough, 2023).

Moreover, due to NI's rich religious history, conscientious objection has been at the forefront of discussions in academia and popular media since the legalisation of abortion (Collins, 2019; Emmerich, 2020; Griffin, 2019). The number of objectors and the impact conscientious objection is having – and will continue to have – on service users, is unclear. There appear to be high rates of conscientious objection, as there is a relatively large and vociferously expressed opposition to abortion in NI (Emmerich, 2020). This opinion has been voiced within the medical profession, as 800 Northern Irish healthcare professionals wrote to the Northern Ireland Secretary expressing their opposition to liberalisation (Connolly, 2019). Also, the Western Health and Social Care Trust, which covers a predominantly rural area ceased providing medical abortion in April 2021 due to 'staff resourcing issues' (Chick, 2022).

Although, findings from studies involving nursing, midwifery and medical staff in NI indicated widespread support for decriminalising abortion up to 24 weeks gestation (n = 169, 54%) and a willingness to provide abortions in certain circumstances (which were not defined) (n = 188, 60%) (Bloomer et al., 2022). Thus, it seems a large proportion of healthcare professionals in NI are willing to provide abortion care. There is a caveat, however, in that these findings are limited as the circumstances in which healthcare professionals would be willing to provide abortion care were not explored. More research needs to be carried out in this area to reach firm conclusions.

NI did not follow the changes introduced in March 2020 due to the COVID-19 pandemic, as telemedical abortion (for both abortion tablets) was introduced to England, Scotland, and Wales. Changes were implemented in order to limit travel and unnecessary contact between individuals, and as a response to the closure of some abortion facilities due to staff sickness and self-isolation (Haynes, 2020). These changes allowed service users to arrange an online consultation with a GP or services such as MSI and BPAS and receive abortion pills in the post. Telemedical abortion is supported by a wealth of literature (Aiken et al., 2018; Chong et al., 2015; Grindlay & Grossman, 2017; Grossman & Grindlay, 2017; Raymond et al., 2015). The Welsh Government made telemedicine for early abortion permanent in February 2022 (Morgan, 2022, Feb 24). At this time, the English Government planned to remove telemedicine in August 2022. However, England decided to make telemedical abortion permanent in March 2022 (Department of Health and Social Care, 2022), and Scotland followed suit in May 2022 (Scottish Government, 2022, May 12). Bacon (2016) argues that legal changes that bring fewer healthcare professionals into contact with abortion, and do not require service users to return to the clinic, are necessary to prevent barriers to abortion, rather than challenging healthcare professionals' beliefs (conscientious objections). However, this only accounts for objections around medical abortion; it does not challenge the issue of surgical abortion.

The Legal Scope of Conscientious Objection

Both the 1967 Abortion Act and The Abortion (Northern Ireland) Regulations 2022 state that individuals (healthcare professionals) do not have to 'participate' in 'treatment' authorised by the Act (Abortion Act, 1967; The Abortion (Northern Ireland) Regulations, 2022). However, there is a lack of clarity over both the terms 'participate' and 'treatment', which has created difficulties in practice and legal cases. As a result, Fleming et al. (2019) request clarification around the term 'participation' and guidelines for practical application. The case of Doogan and Wood – presented below – exemplifies the need for clarification of the said terms and the courts' failure to consider legislation surrounding the protection of conscience and the social implications when defining them (Neal, 2015).

Moreover, UK Parliament has attempted to clarify and extend the extent to which healthcare professionals can refrain from participating in the Conscientious Objection (medical activities) Bill 2017-19. This is scrutinised for supporting the conscience absolutist position of conscientious objection (Wicclair, 2019). In this section I explore the definitions of participation presented in the Doogan and Wood case, attempts to pass the Conscientious Objection (medical activities) Bill 2017-2019, and healthcare professionals' understandings of what 'participation' is.

Doogan and Wood

Two senior Roman Catholic midwives, Mary Doogan and Constanza Wood objected throughout their 20 years practising midwifery. However, due to the restructuring of the profession, both believed they would have to engage with the process of procuring abortion. Their employer stated that they would not have to perform ‘hands-on’ direct involvement with abortion, but would have to provide indirect, ‘hands-off’ care. Doogan and Wood were not satisfied with this arrangement and submitted a formal grievance which was later rejected at Health Board level (Cochrane, 2014; Fleming et al., 2019; Neal, 2015).

Several definitions of ‘treatment’ were explored throughout the process:

- Doogan and Wood claimed that treatment encompasses the entire process of termination “[from] the initial telephone call booking the patient into the Labour Ward to the admission of the patient, to assigning the midwife to look after the patient, to the supervision of the staff looking after the patient, both before and after the procedure, as well as to the direct provision of any care for those patients, apart from that which they are required to perform under section 4(2) [in emergencies]” (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014, p. 672).
- The Health Board claimed that the treatment process begins with the administration of the drugs and ends with the expulsion of the products of conception – foetus, placenta, and membrane, from the womb (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014).
- Lady Hale outlined that the RCM claim that: “the treatment authorised by this Act is limited to the treatment which causes the termination, that is, the administration of the drugs which induce premature labour. It does not extend to the care of the woman during labour, or to the delivery of the foetus, placenta, and membrane, or to anything that happens after that” (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014, p. 671).
- Lady Hale also outlined the 1997 position of the RCM which stated that the fourth clause should be interpreted as protecting healthcare professionals against “direct involvement in the procedure of terminating pregnancy” (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014, p. 672).

Lady Hale endorsed the definition of the Health Board, stating:

“[Treatment] begins with the administration of the drugs designed to induce labour and normally ends with the ending of the pregnancy by delivery of the foetus, placenta and membrane. It would also, in my view, include the medical and nursing care which is connected with the process of undergoing labour and giving birth – the monitoring of the progress of labour, the administration of pain relief, the giving of advice and support to the patient who is going through it all, the delivery of the foetus...and the disposal of the foetus, placenta and membrane” (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014, p. 673).

The Supreme Court then turned its attention to defining ‘participation’. Lady Hale outlined two definitions: ‘hands-on, direct care and ‘hands-off, indirect care’. Specifying the narrower of the two readings, ‘hands-on, direct care’ is likely to be what parliament meant by participation when the Act was passed (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014).

Once these definitions had been agreed, Lady Hale then compared the midwives’ list of tasks to establish what they could object to. It was deemed that they were able to object to the following tasks on grounds of conscientious objection: those involving one-to-one contact or providing clinical judgement, taking over (break relief) from a midwife on duty, being in a position to assist and support if medical intervention is required, making judgements over whether care should be escalated to a more senior/specialist level, and directly providing emergency care (unless covered by Section 4(2)). Tasks that were considered ‘managerial’ and ‘administrative’ were not seen to be covered by the fourth clause. These included: managing resources within the labour ward (arranging abortions over the phone, writing shift handover documents, allocating staff to patients, organising breaks for staff, providing support, guidance, and advice for staff on shift (except when directly linked to a service user accessing abortion), responding to staff requests for assistance, acting as the first port of call when staff have concerns over service users, communicating with professionals (in a managerial capacity rather than to provide an opinion), and providing support to the service user’s family. Thus, a narrow definition of hands-on participation was accepted which did not include ancillary, managerial, or administrative tasks (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014).

A case conference of ethicists and lawyers was convened to discuss the outcomes of the Supreme Court case. The outcome was understood in relation to this case and potential future cases. The unanimous conference finding was that the Supreme Court judgement was not well reasoned and would not be appropriate to use in future cases. This conclusion was based on the fact that there was no rationale for adopting a narrow definition of participation, and the right to freedom of religion or belief, the Human Rights Act, and the European Convention of Human Rights were not admitted into the proceedings (Fleming et al., 2019; Neal, 2014). Thus, the Doogan and Wood case exemplifies the need to understand what participating in abortion constitutes, what healthcare professionals should be able to object to, and the complexities involved in doing so.

Conscientious Objection (Medical Activities) Bill 2017-2019

The case of Doogan and Wood highlighted the need to define the term ‘participation’. It also facilitated the discussion of a private member’s bill sponsored by Baroness O’Loan (Conscientious Objection (Medical Activities) Bill, 2017; Neal, 2014). The Bill was prorogued and there has been no further progress made in passing it as an Act. The Bill outlines a wide interpretation of participation, proposing broad protection for healthcare professionals with a conscientious objection to withdrawing life-sustaining treatment, artificial reproduction, and abortion. The Bill defined participation as including “any supervision, delegation, planning or supporting of staff in respect of that activity” (Conscientious Objection (Medical Activities) Bill, 2017). Therefore, it supported Doogan and Wood’s stance and fits within the ‘conscience absolutist’ perspective.

However, the Bill has been challenged within academia as it failed to incorporate a patient-centred approach, as there was no consideration of the impact such changes would have on service users’ access to abortion and no form of regulation to review the nature and sincerity of the conscientious objection (Wicclair, 2019). This was noticed by the opposition in the House of Lords, as Baroness Young stated that the current conscientious objection clause is "sensible and balanced" and the Bill under discussion is "unnecessary and potentially dangerous" (Parliamentlive.tv, 2018). She then explained her support for the decision made by the Supreme Court in the Doogan and Wood case that healthcare professionals should be able to refrain from 'hands-on' involvement only. Thus, it is evident that the scope of participation is a contentious issue with several practical implications.

Healthcare Professionals' Views on what Constitutes Participation in Abortion

Research uncovers healthcare professionals' views on what constitutes participation in abortion, and their opinions as to what objectors should be able to object to. I make the distinction between the two as they can be seen as questions with different outcomes. I have already addressed the question what healthcare professionals should be able to object to in the section 'ethical perspectives of conscientious objection'. Here, I discuss what the professionals believe participation in abortion entails.

Only a few studies have uncovered healthcare professionals' views on what constitutes participation in abortion. For instance, Maxwell et al.'s (2022) study of objecting and non-objecting British midwives found that what midwives constituted as participation in abortion was varied and complex, as a 'spectrum' of participation was in evidence ranging from 'everything' to 'just giving the service user the medication'. Similarly, Czarnecki et al. (2019) found that healthcare professionals working in a Midwestern teaching hospital (USA) could not give a 'yes' or 'no' answer to whether they participated in abortion due to the complex nature of the term 'participation'.

In Maxwell et al.'s (2022) study, most British midwives adopted a narrow, hands-on approach as they believed that giving the medication to induce the labour was what constituted participation. Yet participants found it difficult to distinguish between pre- and post-abortion, as post-abortion care was considered not part of the abortion and pre-abortion care was seen as a more active element of the process. These findings reflect the narrow versus broad approaches of participation debated in the Doogan and Wood case (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014). Similarly, some nurses in the Midwestern study did not view care given to the service user after the foetus had died as participating in an abortion, as the foetus' life had already ended. In addition, one paediatric anaesthetist commented that they felt removed from participating in abortion as the surgical gown acts as a visual barrier and provides a moral distance from abortion, reducing the sense of participation (Czarnecki et al., 2019). Thus, it is evident that there is no single way of defining participation in abortion, as participation varies according to individuals' roles and their experiences, views, and understandings of morality.

Institutional Conscientious Objection

What constitutes participation in abortion is a contentious issue in the conscientious objection to abortion debate and involves complicated practical and ethical considerations. Another quagmire arises when considering whether institutions should be given legal objector status. Currently, institutions in some countries conscientiously object. In a mixed-methods narrative review, Merner et al. (2023) found empirical evidence for institutional conscientious objection in the following countries: US, Chile, Turkey, Argentina, Australia, Colombia, Ghana, Poland, and South Africa, despite different policies and legislative frameworks. Traditionally, it is thought that it is mainly religious institutions that object (Wicclair, 2011); however, the findings of this study indicate that secular institutions also claim institutional conscientious objection (Merner et al, 2023). Institutional objections may be unwritten and employed due to the personal religious beliefs of hospital administrators (Nowicka, 2008, cited in Fiala & Arthur, 2014). This reflects a different political and social environment to Britain, where institutional conscientious objection has not been reported. There are religious hospitals which are not funded by the NHS, such as the hospital of St John and St Elizabeth (St John & St Elizabeth Hospital, n.d.), but these are few in number and not all hospitals are required to provide abortion. In the following section I investigate the arguments on both sides of the institutional conscientious objection debate.

Firstly, the claim that institutions have the same characteristics as individuals, which would warrant ascribing them the capacity to exercise conscience, has been widely dismissed (Fletcher, 2016). Conversely, it is argued that the said institutions have an identity and integrity to protect and uphold which in turn protects individuals affiliated with the institution (Wicclair, 2011). This argument is used to support the conscience absolutist approach, as institutional objection allows healthcare professionals to work for an organisation that does not endorse abortion. However, referring and informing service users and providing abortion care in emergency situations is still essential as institutions have an obligation to prevent harm (Wicclair, 2011).

Furthermore, Wicclair (2011) also comments that service users could be exposed to serious risks or potential death when attempting to maintain institutional identity and integrity. Such irreparable damage is unacceptable and has been presented in case studies of miscarriage management in Catholic hospitals (Freedman et al., 2008), and in cases in US Catholic hospitals where information on abortion is not given in life-threatening situations (Allen, 2018). Moreover, providing abortion care when it is prohibited by the institution may have negative implications for healthcare professionals, as well as for service users. For example, the director of a Catholic hospital commented in a media interview that staff would be dismissed if they provided abortion, despite its status as a legal service (Pongauer Nachrichten, 2004, cited in Fiala & Arthur, 2014).

Furthermore, allowing institutions to object on grounds of conscience inevitably removes a healthcare professional’s right to conscience when they wish to provide an abortion. This is the same infringement on human rights that the conscientious objection clause aims to protect (Dickens & Cook, 2000; Fiala & Arthur, 2014; Sepper, 2012). This is labelled a positive claim of conscience (Michel et al., 2020; Wicclair, 2009); it is also understood as locating one’s work as ethical and moral through conscience affirmations (Shaw, 2018). Cases of miscarriage management in catholic hospitals highlighted how decisions made by hospital ethics boards (in the US) impacted upon healthcare professionals’ moral integrity and conscience (Freedman et al., 2008). For example, a healthcare professional may consider a termination necessary and lifesaving, but the ethics board may not. This creates an ethical dilemma. Does the healthcare professional break hospital protocol to provide legal lifesaving care, while protecting their own conscience and moral integrity? Or do they go against their conscience and comply with the ethics board, potentially losing a service user? One example given was that of a healthcare professional violating hospital protocol as they snapped a foetus's umbilical cord to stop its heart to satisfy the ethics committees' criteria, as once the heart had stopped, he was able to perform a termination. The healthcare professional was so traumatised and upset that he resigned in order to practise in a non-sectarian academic medical centre (Freedman et al., 2008).

Moreover, quantitative evidence supports the claim that institutional conscientious objection does not work in practice, as 37% of a nationally representative sample (n=1,800) of obstetrician-gynaecologists practising in religiously affiliated institutions in the US stated that they have had a conflict with their institution over religious-based policy (including but not exclusive to abortion) (Stulberg et al., 2012). Thus, although institutions may have an identity and integrity to protect, institutional conscientious objection simplifies conscientious objection by implying that healthcare professionals either object to or provide abortion services. This is not the case, as many healthcare professionals decide on a case-by-case basis whether to provide abortion care and, in certain circumstances, providing such care may be essential according to a healthcare professional's conscience (Lyus, 2017; Smith, 2018). Therefore, permitting institutional conscientious objection removes healthcare professionals' right to follow their conscience and protect their moral integrity when they feel the need to provide abortion care.

It is important to note that institutional conscientious objection is not formally practised in Britain. It can be argued that there is no need for institutional conscientious objection as not all public hospitals in Britain offer abortion services; hence, healthcare professionals can choose to work for organisations that do not provide abortion.

Conscientious Objection and Abortion in Practice

Researching Abortion from Service Users' Perspectives

As I previously note, there is very little empirical research on conscientious objection from the perspectives of service users. In previous decades, this was evident within the literature on abortion, as indicated by Barbara Rylko-Bauer:

"What is missing from so much of this literature, however, are the voices of women, their experiences and perceptions of abortion, the circumstances that shape their reproductive decisions, and the sociocultural context so necessary to our understanding of the ideology, discourse and practice surrounding abortion at the local, regional, national and global levels" (1996, p. 479).

Western feminist scholars have addressed these issues within the abortion literature, focusing on the experiences of service users. Three main bodies of research have been conducted from service users' perspectives: decision-making/reason-giving for accessing abortion, perception of abortion stigma, and the impact of cultural context on aborting (Purcell, 2015). In recent years, there has been an influx of research on how service users access abortion and their experiences of abortion care. Some of this literature highlights glimpses of conscientious objection in practice. In the following sections, I present the findings of research that focuses on service users' experiences of abortion, healthcare professionals and advocates perceptions and experiences of service users accessing abortion, and I contextualise these with studies that investigate how conscientious objection can be a barrier to accessing abortion.

Accessing Abortion

Those who need to access abortion services in the UK (including NI) can do so by directly contacting NHS-funded private facilities such as BPAS and MSI. However, research indicates that there is a lack of education for service users around abortion access in the UK and internationally. Globally service users are often unaware of where and how to access abortion and tend to seek advice from friends, relatives, or online before approaching healthcare professionals, as research from Sweden (Andersson et al., 2014), Croatia (Håkansson et al., 2021), Scotland (Purcell et al., 2014), and global reviews (Culwell & Hurwitz, 2013) indicated.

Moreover, without reputable advice and knowledge of abortion services, service users often visit their GP when accessing an abortion, as they are not aware that this step can be bypassed. Previous research on service users depicts this, for example, in Wiebe and Sandhu's (2008) Canadian study, 61.1% of 402 participants were referred to an abortion clinic by a doctor. Findings from England support this claim, as Finnie et al. (2006) found that 82% of the 132 participants in their study were referred to an abortion advisory service by a GP. Also, British service users commented that they were reliant on their GP due to a lack of knowledge on how to access abortion (Harden & Ogden, 1999). However, these studies were conducted approximately 20 years ago, and hence may not accurately depict the current situation in Britain and Canada. Moreover, I cannot extrapolate the findings to the entire UK, as the context of abortion and sexual education in Canada differ from that of Britain and NI and Finnie et al. (2006) only focused on three London boroughs. Despite this, statements from MSI confirm that the majority of service users are referred to their services by a GP (MSI Reproductive Choices, 2020), and Low et al (2020) found that those who had accessed abortion via self-referral in Scotland believed public awareness on self-referral routes should be increased.

Abortion Care Satisfaction

Over the past 20 years, there has been a drive for quality improvement within healthcare. This has been facilitated by the political, social, and scientific context in the UK. There has been a significant number of healthcare scandals, increased pressure on the health service with an aging population, while healthcare professionals are struggling to ensure that they remain informed about advances in medical scientific knowledge (Gillam, 2022). This focus on quality is reflected in the abortion literature as there has been a growth in research on service users' experiences of abortion regarding satisfaction with care. In the following section I outline the findings of a variety of studies based in Britain and across the world.

Prior studies indicated that most US service users were satisfied with their abortion care (McLemore et al., 2014; Taylor et al., 2013; Tilles et al., 2016) and Swedish service users commented that they were surprised by the non-judgemental attitudes expressed by healthcare professionals and staff (Andersson et al., 2014). For example, US service users in McLemore et al.'s (2014) study reported that first trimester care was ‘about what was’ or ‘better’ than expected.

However, some service users have had more challenging abortion experiences, as voiced by BPAS service users (Whitehouse et al., 2021). How difficult or satisfactory a service user’s abortion experience is can be impacted by the following: how prepared and informed a service user is before their abortion (Altshuler et al., 2017; Whitehouse et al., 2021); how much autonomy the service user has with regard to the care choices made (Whitehouse et al., 2021); how long the service user has to wait to access the abortion (Whitehouse et al., 2021); the clinical environment (Taylor et al., 2013); whether pain levels are managed effectively (Taylor et al., 2013); the extent to which the service user has to compromise their emotional well-being (Altshuler & Whaley, 2018); and the treatment and demure of healthcare professionals, staff (Andersson et al., 2014; Kimport et al., 2012; McLemore et al., 2014; Purcell et al., 2014; Taylor et al., 2013; Weitz & Cockrill, 2010; Whitehouse et al., 2021), and other service users (Whitehouse et al., 2021).

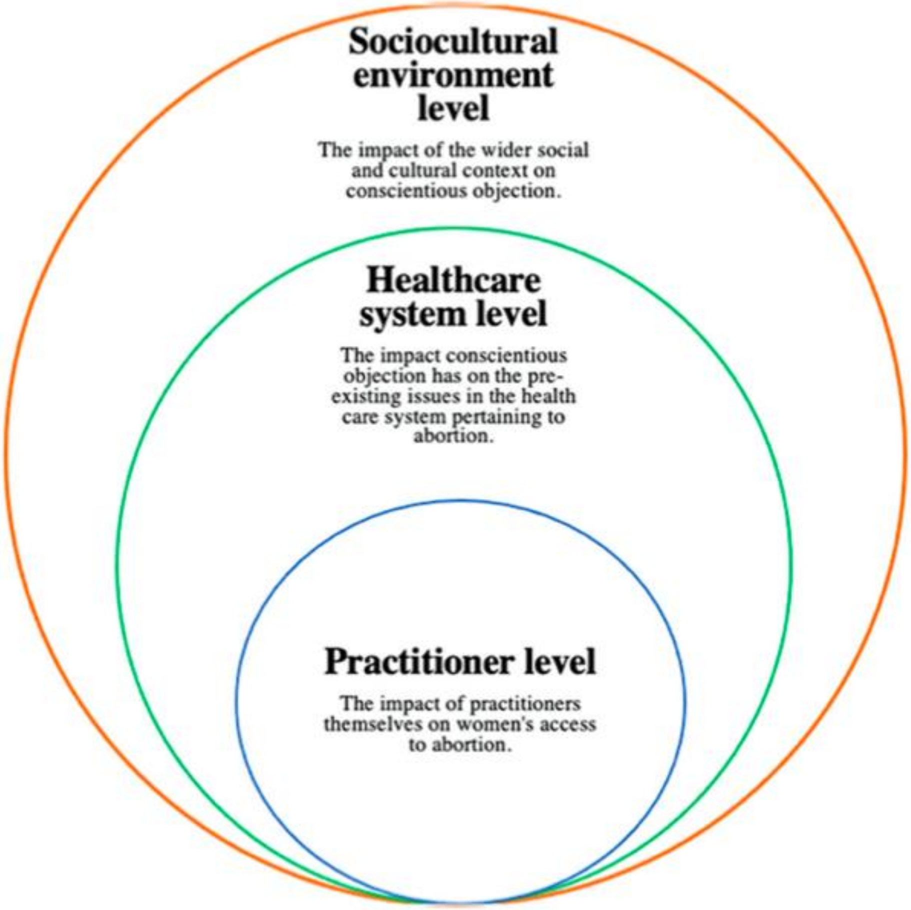
Moreover, Swedish service users reported that healthcare professionals should remain professional, non-judgemental, and empathetic (Andersson et al., 2014). Positive interactions with healthcare professionals and staff were understood by US service users in relation to connectedness, respect, and compassion (Kimport et al., 2012; McLemore et al., 2014; Taylor et al., 2013), as well as having a sense of dignity upheld (McLemore et al., 2014; Weitz & Cockrill, 2010). Such behaviour has been understood by Scottish service users as being ‘comforting’, ‘reassuring’, and ‘there for service users’ (Purcell, et al., 2014) and by US service users as acting in a capacity to reduce their anxiety (McLemore et al., 2014).

Furthermore, findings imply that service users are globally less satisfied with abortion care from their GP than from abortion/family planning clinics. Abortion clinics are associated with high levels of service user satisfaction. In English research this has been attributed to supportive staff attitudes (Finnie et al., 2006). However, Whitehouse et al.'s (2021) study on BPAS contradicts this somewhat, as they found that service users of BPAS had mixed experiences in which interpersonal interactions with healthcare professionals and staff were viewed as both ‘one of the best parts’ and ‘one of the worst parts’ of the service. This indicates that not all staff at abortion clinics are supportive. Moreover, it is important to make the distinction between free and private (non-funded) clinics when making global assessments, as Croatian findings suggest that staff at private clinics were more professional and helpful throughout the abortion journey than those at publicly funded clinics (Håkansson et al., 2021).

Conscientious Objection as a Barrier to Healthcare

In the previous section I highlighted abortion care satisfaction and what service users feel constitutes poor and satisfactory care, particularly in relation to treatment by healthcare professionals and other staff. In the following section I develop this issue, depicting how conscientious objection can be a barrier to service users accessing abortion. I briefly explored this within the section titled ‘incompatibility thesis’. However, I give more of a comprehensive overview in this section. Three important systematic reviews have been conducted in this area. Firstly, Chavkin et al.'s (2017) white paper examines the prevalence, health consequences, and policy responses around conscientious objection. Secondly, a narrative literature review undertaken by Davis et al. (2022) provides insight into the impact of conscientious objection on service users access to healthcare worldwide. Finally, de Londras et al.'s (2023) synthesis of the legal and health evidence illuminates the impact that conscientious objection has on the outcomes of abortion globally. I present the following sections in order to mirror the themes created (as barriers to access) in Davis et al.'s (2022) literature review. Therefore, barriers are understood on a sociocultural environment level, practitioner level, and healthcare system level. Figure 1 depicts the interconnected nature of the levels of impact on service users’ access to abortion.

Figure 1: Barriers to accessing an abortion.



(Davis et al., 2022, p. 2196).

The sociocultural environment has the potential to facilitate high numbers of objectors by normalising conscientious objection and stigmatising abortion and thus limiting the availability of abortion services. In such contexts healthcare professionals may object for non-conscientious reasons due to the stigma attached to providing abortion care and potentially because of fears for their own safety (Davis et al., 2022). Environments that are religious or that stigmatise (community stigma) abortion are highlighted as particularly important in impacting healthcare professionals’ decisions to object, and service users’ experiences of accessing abortion, with regard to availability of services, accessibility of services, and service delivery as depicted in Davis et al's (2022) literature review, and ethical deliberations (Faúndes & Miranda, 2017).

Furthermore, research on service users’ reveals that they are worried about being judged for accessing abortion, particularly in areas where abortion is highly stigmatised. For example, 85% of participants (service users) in a Uruguayan study were worried about being judged for accessing abortion (Makleff et al., 2019). In addition, service users are aware of the impact that the wider cultural context has on the decisions healthcare professionals make, as a Polish survey of 150 abortion service users revealed that 65% of treating physicians supported service users’ decision to abort, but only 8% were willing to perform the procedure. Service users believed this was due to healthcare professionals’ own beliefs or the opinions of wider society (Zareba et al., 2019). Although this cannot be confirmed, as the healthcare professionals were not asked to explain why they did not want to perform the abortion, it provides an intriguing insight into the views of Polish service users at this time. Thus, the context of community stigma creates an environment in which healthcare professionals can object freely (potentially for non-conscientious reasons), and conscientious objection exacerbates the reduction of availability of services created by the stigma.

As well as this, community stigma prevents service users reporting negative experiences in healthcare, including those related to conscientious objection, as discovered in Columbia (Brack et al., 2017), Uruguay (Makleff et al., 2019), and by reviewing the literature (Chavkin et al., 2017). This exacerbates negative treatment of service users in practice in such contexts, and there are no reprocussions, and mistreatment may become common place (Keogh et al., 2019).

A religious sociocultural context also influences service users’ experience of abortion and conscientious objection, including the availability of abortion services. This goes hand in hand with abortion stigma and results in high numbers of objectors, and healthcare professionals objecting for non-conscientious reasons. The literature on healthcare professionals’ perspectives indicates that religion is a common reason for objecting in many countries including Brazil (Darzé & Júnior, 2018; Madeiro et al., 2016), Columbia (Fink et al., 2016), Zambia (Freeman & Coast, 2019), the US (Lawrence & Curlin, 2009),Norway (Nordberg et al., 2014; Nordstrand et al., 2014), and Spain (Toro-Flores et al., 2019). In addition, Minerva (2017) proposes that Italy has a high number of objectors because of its religious sociocultural background. Religion also impacts the institutional level as numerous Christian institutions (in countries such as the US) are objecting to providing abortion care. Additionally, findings on the perspectives of service users indicate that the religious sociocultural context in Croatia creates a discourse that controls service users’ access to abortion, as well as access to information on abortion, by legitimising and normalising conscientious objection (Håkansson et al., 2021).

Healthcare System Level

Conscientious objection is also a barrier to accessing abortion because of the influence it has within the healthcare system. This can be understood in relation to insufficient providers, overburdening abortion providers, increased waiting times for service users, and greater geographical and financial barriers (Davis et al., 2022). I discuss these interconnected issues in the following section.

Firstly, areas that have a high number of objectors such as Italy (Autorino et al., 2020; Bo et al., 2015, 2017; Heino et al., 2013) and Ghana (Awoonor-Williams et al., 2018) create barriers for service users because of the low availability of services. Some areas have such a high number of objectors that no healthcare professionals are willing to provide abortion services (Chavkin et al., 2017; Coppola et al., 2016; Haaland et al., 2020). Italy can be used as an example as it has been reported that between 69.6 and 90% of gynaecologists object (Minerva, 2017). A lack of willing healthcare professionals is likely to render the duty to refer useless as objecting healthcare professionals may be unable to refer service users to providers within a reasonable geographic proximity (Davis et al., 2022).

Moreover, the availability of abortion providers is directly impacted by training opportunities. In some areas, such as Ghana (Aniteye & Mayhew, 2013) and Zambia (Freeman & Coast, 2019) the availability of abortion-related training is stifled by supervisors who discourage healthcare professionals from entering this field due to a conscientious objection, and colleagues who will not support the training of healthcare professionals, as depicted in Victoria, Australia (Keogh et al., 2019). Aniteye and Mayhew's (2013) study highlights the lack of training available in Ghana, one healthcare professional commented that "the few people who want to provide the service might not get access to the medical equipment that may be necessary ... If my head of department is a Catholic and does not believe in abortions, is he going to provide the right set-up for me to carry out abortions?" (2013, p. 9).

Furthermore, it is argued that there is a relationship between insufficient providers and long waiting times (Brack et al., 2017; Freeman & Coast, 2019; Michel et al., 2020). This can lead to service users not being able to access abortion within the gestational threshold stipulated in law (Favier et al., 2018), accessing illegal abortion, and travelling for an abortion. The Italian case has been explored and there appears to be a correlation between low numbers of healthcare professionals willing to perform abortions and long waiting times and high levels of abortion-related mobility. This was understood by controlling for other variables such as geographical proximity of hospitals outside the home region, inter-regional migration, avoidance of social stigma, and general mobility of healthcare services (Autorino et al., 2020). Thus, it is likely that high numbers of objectors are a barrier to accessing abortion.

Moreover, abortion providers may become overburdened when they work in communities with high numbers of objectors such as Italy (Autorino et al., 2020), Ghana (Awoonor-Williams et al., 2020), and Columbia (Harries et al., 2014), this has been supported by Chavkin's review (2013). Colleagues' objections may be based on genuine claims of conscience or for a variety of other reasons that I have explored in the section titled 'objecting on non-conscientious grounds.' For example, healthcare professionals may object due to: (i) community stigma, as discovered in Ghana (Awoonor-Williams et al., 2018), Brazil (Diniz et al., 2014), and Columbia (Harris et al., 2016); (ii) concerns around personal safety, as the assassination of Dr George Tiller in the US presents (Gettig, 2009); (iii) financial reasons, which were found to be important in Columbia (Harries et al., 2014), and the US (Meyers & Woods, 1996), and the desire to undertake a more diverse workload (Wicclair, 2011). Moreover, healthcare professionals may object to avoid being overworked, as work is allocated to other members of staff who do not object (Boama, 2018; Contreras et al., 2011). This creates a toxic circle of abortion provider shortages, as seen in Argentina (Michel et al., 2020). However, it is important to understand burnout and the impact it has on conscientious objection in view of the sociocultural context. For instance, Martin et al. (2014) found that abortion providers based in seven sites across the US (Midwest, South, and East and West Coast) working in public, non-profit, and private hospitals and clinics had lower burnout levels than other healthcare professionals in the US (before *Roe v Wade* was overturned). It would seem that there is a low number of objecting healthcare professionals in these areas.

Finally, conscientious objection disproportionately impacts POC, people with disabilities, LGBTQ+ and non-binary individuals, those of low socio-economic status, and those residing in rural or remote areas (Fry-Bowers, 2020). Findings from Italy (Autorino et al., 2020) and Victoria, Australia (Keogh et al., 2019) indicate that service users living in rural and remote areas must travel to access abortion due to low numbers of staff and high numbers of objectors. Areas of low socio-economic status have similar issues regarding a lack of healthcare professionals, as many professionals relocate to more affluent areas. This is referred to as ‘brain drain’ (Chavkin et al., 2017) and creates additional burdens for service users of low socio-economic status for whom the option to travel may be problematic due to financial barriers. This could result in service users procuring an illegal abortion or continuing an unwanted pregnancy.

Healthcare Practitioner Level

Healthcare professionals not following guidelines around conscientious objection can be a barrier to abortion access. I have discussed this on the following levels: lack of information given to service users, ineffective referral (does not adhere to guidelines), and mistreatment. In this section, I also explore the impact of barriers on service users.

Informing

Findings from Croatia (Håkansson et al., 2021) and England (Kumar et al., 2004) that uncovered service users' perspectives indicate that healthcare professionals who object do not always inform service users that they are able to access an abortion, nor do they provide sufficient information about the procedure and how to obtain it, as uncovered in New South Wales, Australia (Doran & Nancarrow, 2015), Croatia (Håkansson et al., 2021), Britain (Harden & Ogden, 1999), and Canada (Wiebe & Sandhu, 2008) and/or provide information about contraceptives (Håkansson et al., 2021). In some cases, incorrect information was given by healthcare professionals; for example, Purcell et al. (2014) interviewed Scottish service users who had 'late term' abortions and found one participant was advised by her GP that it was too late at 17 weeks for her to have an abortion as the healthcare professional believed the foetus was a baby at that stage. This is not the case under British law (Abortion Act, 1967). Thus, incorrect, and morally loaded information was given to the service user.

Findings regarding the perspectives of non-service users (healthcare professionals, abortion advocates etc.) mirror the experiences of service users. Access has been obstructed by objectors who: (i) did not discuss abortion as an option in Ghana (Aniteye & Mayhew, 2013; Awoonor-Williams et al., 2020), Victoria, Australia (Keogh et al., 2019), and South Africa (Müller et al., 2016); (ii) falsely informed service users of the legal criteria of abortion and claimed they did not meet it, in Columbia (Fink et al., 2016), and Victoria Australia (Keogh et al., 2019); (iii) gave false information about the dangers of abortion (Fink et al., 2016). In some cases, incorrect information was intentionally given in order to obstruct or dissuade the service user, this was the case in Columbia (Fink et al., 2016) and the US (Homaifar et al., 2017) and abusive or harsh language was used by objectors in an attempt to convince service users not to abort (Fink et al., 2016).

Thus, service users' experiences and anecdotes from healthcare professionals indicate that healthcare professionals do not always fully inform service users when they present for an abortion, this can result in consequences for service users, I discuss these in the section below titled ‘impact on service users’.

Referral

Several countries have referral requirements in place that require objectors to refer service users to non-objecting healthcare professionals. In the UK, GPs are mandated to refer service users to a non-objecting GP if they believe it is not practical for the service user to make another appointment (General Medical Council, 2020b). Findings from New South Wales, Australia (Doran & Hornibrook, 2016), Reddit users (globally) (Richards et al., 2020), and Canada (Wiebe & Sandhu, 2008) concerning service users’ perspectives indicate that GPs are not always willing to refer if they have an objection. Findings from England reflect this, as Finnie et al. (2006) found that 15% of 107 participants had to make a second appointment with another GP after the first did not refer them for an abortion. Though it is important to note that direct referral is not set out as a guideline. Also, Kumar et al. (2004) found that in England GPs can cause seemingly intentional unnecessary delays during the referral process, as they referred participants to external services (Brook clinics, over the counter tests, hospital laboratories) to confirm their pregnancies.

Similarly, studies focusing on healthcare professionals’ perspectives indicated that GPs do not always refer service users in Ghana (Aniteye & Mayhew, 2013), Columbia (Fink et al., 2016), the US (Homaifar et al., 2017), and Victoria (Keogh, et al., 2019), or the approach to making referrals is inconsistent and fragmented (de Londras et al., 2023). Lack of referral has been described as common practice in rural Victoria, Australia (Keogh, et al., 2019). As I previously noted in the section titled ‘conscience absolutism’, healthcare professionals refrain from referring service users as they believe the referral process makes them morally complicit in the abortion (Cavanaugh, 2010; Minerva, 2017; Oderberg, 2017; Trigg, 2017). Thus, it seems this lack of referral or fragmented referral is for moral reasons. Some healthcare professionals have managed to circumvent referral requirements. For instance, objectors in South Africa and Zambia made impractical or vague referrals such as referring service users to facilities which were far away, or had service users return for multiple appointments with different healthcare professionals in an attempt to cause delays (Freeman & Coast, 2019; Müller et al., 2016). Similarly, GPs in Victoria (Australia) (Keogh et al., 2019) and England (Kumar et al., 2004) requested that service users return at a later date after reconsidering their decision, even though this is not a legal or health-based requirement. Though it could be argued that English GPs are doing this 'in good faith' to ensure the service user meets the criteria set out in law. Shaw (2018) argues that refusing to refer can prevent pregnant people from accessing abortion and reinforce the stigma and judgement around abortion, as healthcare professionals are inadvertently sending the message that they do not want to be associated with abortion and that it is shameful. Thus, findings from service users and healthcare professionals' perspectives worldwide and from Britain reveal that GPs are not always willing to refer service users when they have a conscientious objection.

Moral Judgement

Findings regarding service users' perspectives indicate that service users can experience moral judgement from objecting healthcare professionals. GPs have attempted to make service users feel guilty about their decisions by making derogatory comments, as discovered in Croatia (Håkansson et al., 2021) and have imposed their beliefs, while challenging the service users reproductive decisions in an attempt to change their trajectory, this has been uncovered in Australia (Doran & Hornibrook, 2016), Britain (Harden & Ogden, 1999), and Canada (Wiebe & Sandhu, 2008). This treatment has been described as 'traumatic' by English service users (Finnie et al., 2006, p. 17). Also, service users in Columbia have been treated extremely poorly by healthcare professionals who have moral judgements but do not object. For example, healthcare professionals have presented foetuses to service users after they had been removed, posed questions such as "You can already hear the heartbeat; how are you going to kill it?" (Brack et al., 2017, p. 178) and told service users about the horrible ways in which they would dispose of their 'babies' (Brack et al., 2017). In addition, Reddit users explained that after they had made it clear that they wished to abort, some non-objecting healthcare professionals showed them sonograms and talked about the foetus in the same way that they would if they wished to continue the pregnancy (Richards et al., 2020).

Furthermore, there is evidence from research on healthcare professionals from Ghana (Aniteye & Mayhew, 2013; Awoonor-Williams et al., 2020), Columbia (Fink et al., 2016; Harris et al., 2016), Australia (Keogh et al., 2019), and Tunisia (Raifman et al., 2018) that indicates that some healthcare professionals have imposed moral judgements on service users by trying to convince them not to abort. For instance, such professionals have attempted to make service users feel guilty for deciding to abort in Australia (Keogh et al., 2019), employed scare tactics and outlined false dangers of abortion in Columbia (Fink et al., 2016) and showed service users images of the foetus to scare them into continuing the pregnancy in South Africa (Müller et al., 2016). Moreover, findings indicate that healthcare professionals can cast moral judgements upon service users, and these can affect the care received.

Impact on Service Users

The literature on service users' perspectives highlights three main ways in which conscientious objection can impact their abortion journeys: by creating delays, having a negative emotional impact, and causing service users to question their morals regarding accessing abortion. Research on healthcare professionals' perspectives, or literature that has analysed the situation regarding conscientious objection, tends to comment on the financial and time burdens placed on service users, and the impact on maternal mortality and morbidity in certain contexts.

Firstly, delays to obtaining abortion have been reported by service users in England (Finnie et al., 2006; Kumar et al., 2004), Canada (Wiebe & Sandhu, 2008), Australia (Doran & Hornibrook, 2016), Columbia (Brack et al., 2017), Croatia (Håkansson et al., 2021), and Reddit users across the world (Richards et al., 2020). Kumar et al. (2004) found that delays were caused by healthcare professionals giving service users more thinking time, referring them elsewhere so they could confirm that they were pregnant and to avoid discussions around abortion. For Richards et al. (2020), the paternalistic nature and unsupportive actions of healthcare professionals and parents towards service users acts as a barrier to abortion, and in extreme cases results in service users proceeding with the pregnancy as they lacked the autonomy to take control of the situation.

Moreover, research that focuses on the experiences of healthcare professionals also found that delays in abortion access or no access were a result of conscientious objection, globally (de Londras et al., 2023), in Columbia (Fink et al., 2016), in Zambia (Freeman & Coast, 2019), in Australia (Keogh, et al., 2019), in Argentina (Michel et al., 2020), and in South Africa (Müller et al., 2016). For example, one Australian service user was falsely misled by her doctor who railroaded her into continuing the pregnancy (Keogh et al., 2019). Also, studies suggest that individuals in rural areas may experience delays in abortion care due to conscientious objection due to poor availability of services (Chavkin et al., 2017), Australia can be used as an example of this (Doran & Hornibrook, 2016). Furthermore, Favier et al. (2018) and Haaland et al. (2020) imply that conscientious objection and attempts to obstruct service users' access to abortion in South Africa have caused delays and resulted in unsafe and illegal abortion.

In addition, causing delays to service users – and conscientious objection in general – can impose financial burdens, as found in South Africa (Harries et al., 2014), including further travel costs, this has been uncovered in Italy (Autorino et al., 2020), and globally (Chavkin et al., 2017), additional administrative burdens, which have occurred in Columbia (Harris et al., 2016), and costs in terms of time (de Londras et al., 2023). Financial burdens tend to disproportionality impact those who are of low socio-economic status (Fry-Bowers, 2020).

Service users have also reported that the actions and opinions of healthcare professionals have had a negative emotional impact on them. Chana, who was interviewed in Brack et al.'s (2017) study in Columbia, commented that she could not sleep because of the way one of the nurses treated her "[a]t night I still see the images of everything that happened...the image comes to me of the nurse saying 'You're a sinner' and then the image of the bag...it all mortifies me" (Brack et al., 2017, p. 178). Findings from Canada and England also support the claim that healthcare professionals who refuse to refer service users and provide information cause emotional distress and discomfort (Finnie et al., 2006; Wiebe & Sandhu, 2008). Moreover, one Australian service user commented that the interaction with her healthcare professional was horrendous after the professional advised her to have an amniocentesis test, despite her decision to abort (Doran & Hornibrook, 2016). Findings from the US indicate that barriers to accessing abortion such as being refused an abortion due to gestation time (it is not noted if this is within legal limits) and being delayed three or more days, were significantly associated with anxiety symptoms (Biggs et al., 2020). This indicates that barriers to abortion associated with conscientious objection can have a negative emotional impact on service users.

Findings also indicate that numerous service users in Ghana (Aniteye & Mayhew, 2013), Brazil (Diniz et al., 2014), Zambia (Freeman & Coast, 2019), South Africa (Harries et al., 2014), and Australia (Keogh, et al., 2019) have been left feeling uncertain about aborting after experiencing moral judgement and or misinformation from an objector. This could be caused by service users believing that a healthcare professional’s understandings and beliefs are superior due to the paternalistic nature of healthcare (Richards et al., 2020). If service users are uncertain, they may take more time to decide whether they should have an abortion, resulting in delays to abortion access or no abortion access at all (Richards et al., 2020). Findings reporting the perspectives of healthcare professionals indicate that service users who experience moral judgement and or misinformation from healthcare professionals may experience an increase in guilt and discomfort. Thus, literature from the standpoint of service users and healthcare professionals indicates that ineffective conscientious objection (that does not comply with guidelines) can result in delayed abortion access, no access to abortion in extreme circumstances, negative emotions and can leave service users questioning their morals.

In addition, in extreme contexts, conscientious objection has been linked to high rates of maternal mortality and morbidity, as illuminated in Chavkin (2013) and de Londras et al.'s (2023) literature reviews. This is due to a shortage of experienced and qualified healthcare professionals, which in turn results in delays to services. Such impact is context-dependent and has been found in areas such as sub-Saharan Africa (Lema, 2012), Mexico, Bolivia (Küng et al., 2021), and Chile (Montero & Villarroel, 2018).

Additionally, it is likely that the impact that conscientious objection has on service users, as well as mistreatment by healthcare professionals goes unreported, as service users may not be aware of the law surrounding conscientious objection and are unlikely to report negative experiences (Richards et al., 2020). This reflects the paternalistic nature of healthcare and reinforces the lack of repercussions for healthcare professionals who do not object in accordance with guidelines. This issues will be exacerbated when the sociocultural environment facilitates conscientious objection.

Regulating Conscientious Objection

Whether conscientious objection should be regulated and the way in which this should be implemented forms another debate within the conscientious objection literature. Most of the literature focusing on regulating conscientious objection is concerned with the validity of a healthcare professional's objections. In the following section I present the arguments surrounding how healthcare professionals' claims of conscience should be regulated. I then introduce two approaches to regulation that specifically focus on the outcomes of conscientious objection and the human rights of service users.

Firstly, some scholars believe that numerous healthcare professionals object on non-conscientious grounds; therefore, they are not aiming to protect their conscience and moral integrity. This is deemed problematic as it directly relates to limiting service users' access to abortion unnecessarily and unjustly (Card, 2016; Hughes, 2017; Zampas, 2013). However, this claim needs to be contextualised as it is argued that healthcare professionals are unlikely to object for non-genuine reasons in the UK, as the gains of objecting are not as high as in other contexts (Cowley, 2016a). Thus, Cowley believes the status quo and system in place is acceptable and fair, meaning that regulation of the reasons why healthcare professionals object is unnecessary. It is important to note that Cowley dangerously presents this opinion as fact, as he has no empirical evidence to support his claim that healthcare professionals in the UK do not object on non-conscientious grounds.

Conversely, those who believe conscientious objection should be regulated propose that this should consider the genuineness or reasonableness of the conscientious objection. Meyers and Woods (2007) present a six-point uniform set of criteria centred around genuineness which they believe should be utilised in tribunals like those used by the military to regulate conscientious objection and establish conscientious objection status. The criteria are as follows:

"1. The applicant must have a sincere scruple-based objection to the procedure;
2. That scruple must fit within an otherwise coherent system of moral or religious beliefs;
3. The scruple must be consistent with other beliefs and actions with respect to, in particular, activities related to the taking of innocent life;
4. The scruple must be a key component of the petitioner's moral or religious framework, such that its violation, and the concomitant violation of her autonomy, represents a greater moral harm than would the corresponding restriction of the client's rights;
5. All reasonable alternatives must be explored, for example, finding another pharmacist to provide the requested medications;
6. Especially in those cases of public employment, and perhaps in all cases, when exemption is granted, some alternative form of public-benefiting professional service should be substituted" (Meyers & Woods, 2007, p. 20).

Card (2016) proposes a similar approach in terms of practicality and the tribunal setting. However, his core focus is on reasonability rather than genuineness, though genuineness is something he touches upon. Card argues for the need to develop a "reasonability standard to perform the essential function of assessing reasons" (p. 222) and to remove objections based on discrimination, empirically mistaken beliefs, and other unjustified bias. He also outlines intrinsic and extrinsic considerations that should be addressed. The intrinsic perspective poses the following questions: 1. Is the belief genuine? Can evidence of this be provided? 2. Is the belief consonant with empirical data? meaning that it is not based on false knowledge.

Cavanaugh (2010) similarly proposes that the belief should be empirically grounded and suggests that the healthcare professional should be able to give reasons that are accessible to others, rather than giving an entirely personal stance. Card argues that the external factors that have to be considered are: 1. if the objection will cause needless or unjustified harm; 2. if the objection is based on self-interest and does not respect the service user-healthcare professional power dynamic; 3. if the objection is fuelled by discrimination, and 4. The principle of providing care in emergency situations and in a time-sensitive circumstance should not be violated.

Similarly, Reichlin (2022) developed the reasonableness criteria to create a four-point system of regulation for those working in medicine. The first requirement is that the belief should be a moral rather than a scientific one. Secondly, the belief must not be inherently violent, discriminatory, or intolerant. Thirdly, the moral belief should be plausible, rather than based upon scientifically or philosophically disreputable views. Finally, the beliefs justifying the doctor's objection should be part of a conception of good medicine which is reasonable and respectful of basic values and liberalism. Therefore, it is evident how tribunals could perhaps work in practice from either a genuineness or reasonability-based perspective.

However, it is argued that neither reasonableness nor genuineness can be assessed at a tribunal. This would render medical tribunals a pointless bureaucratic exercise, whereby individuals have to convince others of their religious and moral beliefs (Cowley, 2016a; Marsh, 2014). Marsh (2014) argues that reasonableness could be too easy or too difficult to satisfy, which would question the validity of medical tribunals. Also, in the case of military tribunals, religious affiliation and therefore association with a religiously informed conscience is measured by membership of a 'peace church'. Cowley (2016a) argues that many Catholics do not agree with the stance Catholicism takes on abortion, thus membership of the church alone is not enough. He also rejects Brownlee's (2012) position that objecting healthcare professionals should have demonstrated some commitment to their principles through activism or public engagement, arguing that this is too demanding and ignores the reasons why healthcare professionals may not involve themselves in such activities (Cowley, 2016b). Neal and Fovargue (2016) also reject regulating conscientious objection in such ways, arguing that it is far too subjective to test the permissibility of objections, as plausibility will be dependent on the background, inclinations, and prejudices of those regulating the objection. Issues around validity, genuineness and reasonability therefore appear to imply that utilising tribunals is not the answer.

However, Hughes (2017) argues that validity alone does not render tribunals useless, as face-to-face encounters can elicit a sense of the objector's sincerity. He acknowledges that this may put those able to articulate their beliefs at an advantage but legitimises this by stating that we already do this as a society in job interviews and court cases.

Ben-Moshe (2021) offers a solution to issues surrounding: healthcare professionals' unfair disadvantage in articulating their beliefs, the financial costs of tribunal, moral complicity around referring and informing, and judging genuineness and reasonableness. This solution is based on 'making it public' and a representative committee would assess various well-known objections in terms of public reasoning to decide which should be permitted. The panel would be diverse and informed and would assess new unique objections as they arise. Objectors would not have to refer and inform but would be required to register their objections online ahead of time on a public database. This offers a practical approach which removes many of the issues around tribunals. However, the database element of this framework is flawed like tribunals in general as it requires healthcare professionals to present a predetermined conscientious objection, which may not always be possible (Lynch, 2008).

An alternative approach to regulation involves focusing on harm prevention (Hughes, 2017) and human rights (Tongue, 2022). These approaches offer a more direct way of protecting service users. Firstly, instead of challenging healthcare professionals on why they are objecting, the outcome of such objections should be the principal focus. Hughes (2017) advocates for regulation of conscientious objection by requesting that healthcare professionals who wish to object provide a plan of action detailing how service users will be able to access abortion after they have objected. Whilst this approach appears pragmatic, it again discounts the fact that healthcare professionals have to pre-empt objections, which may not be possible as such professionals may object to individual cases and may not have a history of objecting (Lynch, 2008). Furthermore, providing a plan for service users does not necessarily mean healthcare professionals will follow through with the process they have documented, as this aspect is self-regulated.

Moreover, Tongue (2022) argues that the self-regulated nature of mandatory referral mechanisms is inadequate in balancing service users and healthcare professionals' rights in multiple contexts and should not be presented as a compromise position. She deems this problematic as she argues that many healthcare professionals will not refer service users and sees this as an inadequate compromise, particularly in areas where refusal to refer is a widespread issue. She proceeds to explain that mandatory referral cannot address widespread conscientious objection, as this requires regulation beyond the level of the individual healthcare professional. Nevertheless, Tongue (2022) does comment that context is key and believes that further regulation is not necessary in the UK, as service users can access abortion by self-referring to BPAS and MSI. However, she does not consider that the majority of service users approach their GP for a referral to these services (MSI), where they could come into contact with an objector. Tongue then elaborates upon her UK stance by claiming that further regulation would infringe the right to freedom of conscience. Moreover, she believes that international human rights bodies should obligate states – with high numbers of objectors – to implement regulation to ensure service users can access abortion. Instead of giving clear guidelines for widespread regulation, Tongue argues that states should address the issues individually due to the differing impact of conscientious objection.

Most discussions around regulating conscientious objection assume that discriminatory objections should not be protected, and hence attempt to address these. However, Ancell and Sinnott-Armstrong (2017) take the opposite approach and do not label discriminatory objections as problematic, instead adopting a market-based approach. They argue that doctors possess the freedom to determine the scope of their practice and therefore can object, even on discriminatory grounds. They make a comparison between two objecting doctors: one who believes individuals should have access to abortion, but objects because they wish to avoid the costs and risks of providing abortion care, and another who objects because they believe abortion is murder and morally wrong. Ancell and Sinnott-Armstrong argue that both objections should be accepted as they fall within the range of freedom doctors must define the scope of their practices.

Furthermore, scholars have presented various ways of tackling regulation, ranging from questioning the validity of healthcare professionals' objections to ensuring that service users have access to abortion. Importantly, however, a case has not been made to regulate conscientious objection in the UK as it is argued that at a healthcare professional level, GPs in the UK are unlikely to object for non-conscientious reasons, whereas at a structural level, the exitances of services like BPAS and MSI mean service users are less likely to come into contact with objectors (Cowley, 2017).

Conclusion

In this literature review I have presented and critiqued the literature surrounding conscientious objection to abortion. Before doing so, I created a conception of conscience that incorporated the main principles of the definitions of conscience that focus on integrity. I defined conscience for the sake of this programme of research as – **a mechanism for passing judgment on one's actions and inactions that is largely fuelled by emotional responses, a commitment to be moral, and to preserve one's personal identity and integrity**. I presented the reasons why healthcare professionals object and concluded that they do so for a range of religious and secular reasons, some of which can be labelled false objections (when healthcare professionals object on non-conscientious grounds). I then presented literature that sets the scene for conscientious objection, which can be divided into literature that focuses on the ethics of conscientious objection and literature that concentrates on the law. The main contributors to the conscientious debate are therefore philosophers, lawyers, and ethicists. There are three main ethical approaches to conscientious objection: the incompatibility thesis, the middle-ground approach, and conscience absolutism. The middle-ground approach is the most popular approach in academia and in practice and is somewhat supported by law and policy surrounding conscientious objection in the UK. Despite this, international and UK-based literature highlights the barriers to abortion that conscientious objection can cause in practice. Most of these accounts are outdated, do not consider service users' perspectives, or do not seek to uncover the impact of conscientious objection. These factors limit the contribution they can make to current debates surrounding conscientious objection. My programme of research fills this gap by providing a current in-depth insight into service users' experiences and views on conscientious objection.

In the following chapter, I discuss the methodological foundations of my programme of research.

Chapter Three: Methodology

Introduction

In this chapter I present the methodological foundations of my programme of research. I outline the research design and its philosophical underpinnings, ethical considerations, and the methods I employed to collect and analyse the data. I conclude with a discussion surrounding trustworthiness and how I ensured this throughout the research. Throughout the chapter, I outline the reasoning behind methodological decisions, and consider alternatives where relevant. I include quotes from the interview transcripts as reflective ‘stop offs’ to support the methodological decision-making process.

Philosophical Underpinnings

Ontology

Ontological perspectives are informed by the researcher’s overarching philosophical views on the nature of ‘existence’ and ‘reality’ (Robson, 2002). The underlying question that informs one’s ontological stance is whether social entities can and should be considered objective entities which have a reality independent of social actors, or whether social actors construct social entities and social reality. These perspectives are labelled objectivism and constructivism, respectively. If reality is perceived as objective, it has observable and measurable traits, whereas if it is socially constructed there are no concrete measurable ‘truths’, only fluid mutable constructs (Clark et al., 2021).

I adopted a feminist constructivist stance for this programme of research, combining feminism and social constructivism to generate a stronger empirical and theoretical understanding of social reality (Locher & Prügl, 2001). I retained the basic tenets of social constructivism; these posit that social actors and systems are co-constituted, whereby social actors simultaneously shape and are shaped by social structures, meaning there is no one constant social reality (Clark et al., 2021). However, by employing a feminist standpoint, I incorporated areas seldom theorised by constructionists such as the social construction of power, how gender and power reproduce, and why some constructs are more influential than others (Locher & Prügl, 2001). Similarly, the nature of participants' experiences benefited from a feminist ontological position as most of the participants were women navigating femininity and what it means to be a woman in the context of the UK, which impacted their own constructions of reality. I did not view experiences presented by the participants as 'truthful' accounts. Instead, I saw them as co-constructions of their version of reality which may differ from the accounts of others, for example, healthcare professionals. I also understood that the power relations between the participant, healthcare professionals, and wider society could exert an influence their social reality. Moreover, feminist constructivism offers a more critical and political analysis of social reality than constructionism alone, as power is deemed crucial in the process of construction (Locher & Prügl, 2001).

Epistemology

Epistemology concerns what is (or should be) regarded as acceptable knowledge (Clark et al., 2021). A central question here is: should we measure social reality using the same procedures and principles as the natural sciences?

I initially considered using a mixed-methods approach, I would have employed both positivist and interpretivist epistemology. I would have conducted a large-scale structured survey and followed it up with semi-structured interviews. I would have potentially quantified the percentage of service users who had encountered an objecting healthcare professionals to provide a more generalisable account of opinions and experiences of conscientious objection. However, given the potential sensitivity of the issue being discussed, the large sample size needed for generalisability, and issues surrounding credibility (participants understanding what conscientious objection is and if they had experienced it), I opted for a solely qualitative research approach.

In addition, interpretivists support the social constructionist ontological belief that knowledge is constructed, as they believe individuals interpret their experiences of and in the world. Thus, knowledge cannot simply be identified and collected as it is in the natural sciences because it is not generalisable and universal. Instead, it is subjective and grounded in our: individual life experiences, values, and the local and political (Hiller, 2016). I aimed to gain access to the developed meanings participants brought to their experiences, utilising a qualitative approach that fitted within this paradigm.

Evolution of Philosophical Underpinnings

My own ontological and epistemological stance was informed by debates and the knowledge I developed while studying undergraduate level sociology at the University of Warwick. Here, the Sociology Department took a pro-qualitative stance, largely rejecting positivism and objectivism. I was encouraged to discover my own ontological and epistemological position, affirming this within my research methodology. My focus was on how individuals experience reality, using qualitative methods to understand this. A feminist constructionist, interpretivist viewpoint has always been attractive to me as I believe social reality is constructed by individuals though power relations must be examined using an intersectional approach. Thus, social reality cannot be studied using methods appropriate for the natural sciences.

Moreover, my ontological standpoint did not change throughout the study, as I took the position that "researchers cannot adopt one position at one time for one project and another on another occasion for a different project. These positions are not interchangeable because they reflect fundamental different approaches to what social science is and how we do it" (Marsh & Furlong, 2002, p. 21). However, I disagree with Marsh and Furlong (2002) on the development of epistemology, as although I have a preferred epistemological stance, I also understand the need to employ a positivist epistemology when researching certain topics.

Furthermore, I was forced to question my epistemological and methodological standpoint whilst studying at the University of Oxford, as the Sociology Department took a mixed-methods standpoint and tended to idealise quantitative research and positivism. This challenged my pre-existing conceptions of such an approach, as I understood the importance of collating representative quantitative data, provided the study has internal validity. After I learnt to code and analyse data in this way, I appreciated the need for quantitative methods to address certain research questions but was wary about the construction of definitions in research and was aware that interpretations of findings as correlation cannot be labelled causation. However, despite this, my preferred standpoint was that of feminist social constructivism.

Theoretical Framework

Liberal Feminism

Current research on conscientious objection approaches the issue by researching the views and experiences of healthcare professionals and discussing the ethical, legal, philosophical, and financial aspects of conscientious objection. However, the impact conscientious objection has on service users is of the upmost importance (Freeman & Coast, 2019; Stulberg et al., 2012) and the first-hand accounts of service users have not been adequately researched. I employed a liberal feminist theoretical framework to combat this issue and to challenge the unequal power dynamic faced by women and pregnant individuals in society. I provided a platform for service users to share their experiences and thoughts, at a time when their voices are largely excluded from the great tradition of Western political philosophy and law-making processes (Dickens, 2014; Levit et al., 2016; Okin, 2013; Paxton & Hughes, 2007). Thus, I gave service users the opportunity to have their say on matters that have the potential to impact their reproductive rights, whilst challenging the systematic devaluation of their voices within the context of patriarchy (Beard, 2017) and the paternalistic power dynamics of healthcare. Although attempts have been made to include the voices and experiences of women in some areas of law and policy creation (Carra, 2008), I adopted a liberal feminist perspective to extend this practice to conscientious objection to abortion.

Moreover, I decided to implement a liberal feminist theoretical framework, this meant that power and law were situated at the heart of the research, as liberal feminists posit that change and equality can be achieved by legal reform (Oxley, 2011). I saw the impact that conscientious objection law and policy has on service users as paramount. In addition, I utilised liberal feminist theory as I worked within the current legal infrastructure rather than overhauling the existing mechanisms and power dynamics in place within the legal system (Oxley, 2011). This meant that the policy implications I drew from the research offer practical solutions to the potential issues faced by service users in the UK.

Wicclair's Ethical Framework

In addition to liberal feminism, I drew upon Wicclair's (2011) threefold framework of conscientious objection. Thus, I understood participants' views and experiences in relation to the 'incompatibility thesis', 'conscience absolutism', and 'compromise' or what I term the 'middle-ground approach' (to avoid loaded language). This pre-existing theory provided me with a logical framework for understanding participants' experiences and categorising their views of conscientious objection.

Combining Wicclair's Ethical Framework and Liberal Feminism

Radical accounts of conscientious objection describe it as an inevitable barrier to individuals accessing abortion. For example, Orr (2017, p. 34) comments that, "[t]he issue of conscientious objection by healthcare staff can have serious consequences for the availability of reproductive healthcare, even when abortion is legal." Fiala and Arthur are two well-known advocates for abolishing conscientious objection who write from a radical perspective. Their primary concern is to protect the human rights of service users, to avoid discrimination and harm to health (Fiala et al., 2016). This position is supported by the latest WHO abortion care guidelines which emphasise the harm of conscientious objection on service users (World Health Organization, 2022).

Moreover, both Orr (2017) and Fiala and Arthur (n.d.) present examples of harm that has occurred due to the conscientious objection clause. Orr (2017) focuses on Sicily, while Fiala and Arthur (n.d.) present cases from Poland, the US, South America, Central America, Spain, New Zealand, and Ireland (pre-referendum). The following example is from Poland:

"[P]regnant woman Valentina Milluzzo died in October 2016 in a Sicilian hospital after anti-abortion doctors refused her a termination. This was after she had gone into septic shock when one of the twins she was carrying died in the womb. Her death – in an obstetrician and gynaecology hospital in a country where abortion has been legal since 1978 – is a warning of how conscientious objection can undermine women's legal rights" (Orr, 2017, p. 34).

The majority of cases presented by Fiala and Arthur (n.d.) cite institutional conscientious objection or illegal actions of healthcare professionals as the main reason for service users suffering. Thus, the context of conscientious objection is largely ignored and labelled inherently problematic. Clipsham (2013) challenges this more radical approach by adopting a liberal perspective and argues that conscientious objection can work effectively by shaping the law to balance the rights of healthcare professionals and service users, with the rights of the latter taking precedence. He states, "[i]t seems, then, that there may be good reasons to endorse policies that allow healthcare professionals to exercise their rights and maintain their moral integrity, but any policies must explicitly rule out CRs [objections] that undermine women's reproductive autonomy, threaten to harm women seeking healthcare or permit otherwise unacceptable CRs"(Clipsham, 2013, p. 60). I built on Clipsham's approach with the addition of further regulation, as well as legal change. I adopted a liberal feminist position (in this programme of research) on conscientious objection in the UK in order to balance the rights of healthcare professionals and service users, with service users' access, well-being, and human rights at the forefront (Zampas, 2013).

Ethics

Setting the Scene for Ethical Clearance. The Context of Abortion in the UK

The contemporary political and social context of abortion in the UK frames abortion as “always a tragedy” (Love, 2017, p.82). This is evident in the rhetoric presented by the far right, numerous religious groups, and the anti-abortion movement. Such groups frame abortion as an inevitably traumatic event, thus reinforcing a trajectory of trauma (Suk, 2010). However, these two principles are also apparent within the pro-choice movement and permeate medical discourse and the mass media, reinforcing the idea that those who access abortion are vulnerable. This paradigm was reflected within the institutional ethics review I undertook.

Moreover, ‘abortion as a tragedy’ is often discussed within the pro-choice movement to redirect the conversation to the causes of abortion and how abortion numbers can be reduced. For example, Labour MP Diane Abbott stated:

“We have heard the concerns about high levels of abortions and repeat abortions. Let me say from the Opposition side of the Chamber that we all share those concerns. Every abortion is a tragedy. I think that we would all in this Chamber want levels of abortions to come down, but we do not fairly bring down levels of abortions by restricting women’s right to choose” (Parliament UK, 2012).

Although the negative emotions associated with abortion should not be undermined, associating abortion with tragedy inherently increases the stigma around abortion. Moreover, it does not reflect the narratives of those who have had neutral or positive experiences. Coleman et al. (2005) stated that “the psychological literature at the level of individual decision-making and adjustment has tended to suggest that the termination of an unplanned pregnancy is an emotionally benign experience for most women” (p. 238). Also, Kero, Högberg and Lalos (2004) found that most women in their study did not experience any emotional distress post-abortion and almost all reported that they had coped well one year after their abortion. Almost all participants described the abortion as a relief, and more than half described positive outcomes such as mental growth and maturity. However, it is important to note that all participants – excluding two – were in their first trimester, and that this study was conducted in Sweden. Nevertheless, similar findings have been reported in studies based in the US that investigate late term as well as first trimester abortion (Rocca et al., 2015).

Reflective stop off:

The need for pre- and post-abortion counselling was raised by several service users.

Tia described how she had initiated her own post-abortion service based on her experiences and needs.

"I just try and make people know there is sometimes grief after abortion. Sometimes it's not going to be all happiness, and you know you can continue with your dreams, yes. But part of it - there should be more information on all the options and the impact and support for after."

Tia clearly explained that individuals 'sometimes' experience grief post-abortion and that her aim is to try to help those who do. However, the anti-abortion movement wishes to take this one step further by enforcing mandatory counselling before and after abortion (Rubin & Russo, 2004).

Although not all participants presented negative or traumatic experiences of abortion, Bao presented her abortion experience in a matter-of-fact manner with little emotion, commenting, "[i]t was an easy process. They all [healthcare professionals] just went for it".

Moreover, there is an assumption that those who access abortion will experience negative emotions post-abortion (abortion trauma syndrome) and need a specific amount of time to consider whether to abort. This syndrome has been widely debunked within the medical community (Rubin & Russo, 2004). Nevertheless, it is depicted within the mass media, thereby influencing public opinion. For example, print media in the UK (The Sun and The Mirror) have depicted abortion as traumatic and terrifying (Purcell et al., 2014). Similarly, an analysis of US television and film representations (often consumed in the UK) revealed that abortion is often presented as a torturous decision with negative consequences. This was reflected in the British soap opera EastEnders, where the character Stacey's abortion was presented as traumatic and coercive and she questioned whether it was the right thing to do post-surgery (EastEnders, 2010, May 13).

Institutional Ethics

I gained ethical approval from the Liverpool John Moores (UK) University Research Ethics Committee (reference: 20/NAH/001). Issues arose when I was navigating ethical approval, as the cultural assumptions of "abortion as a tragedy" (Love, 2017, p.82) were reflected in the research ethics board requirements because abortion was framed as a high-risk and distressing topic. This partly recognised the complex range of emotions individuals experience, but simultaneously labelled all participants as high risk and potentially vulnerable. Thus, it reinforced the stigma surrounding abortion and the assumption that abortion is always distressing (Love, 2017). This has been discredited in the literature, as in reality most individuals experience both positive and negative emotions when accessing an abortion (Kero et al., 2004; Rocca et al., 2015). The ethics board also inquired as to whether I would assign a time frame outlining when it was appropriate to interview participants post-abortion to avoid emotional distress. I explained that assigning a time frame would be arbitrary and unhelpful, as everyone's abortion experience differs. This statement alongside examples of studies that had researched participants immediately after their abortion satisfied the ethics committee. Moreover, a plethora of abortion experiences should inform research ethics, treatment, and the understanding of participants, but it was difficult to reflect this within the current institutional ethics review process.

Emotional Distress

As I previously mentioned, the ethics committee labelled my research high risk, and one of their main concerns was that participants would become emotionally distressed. Although this may not have been the case for all participants, I cannot deny the importance of having procedures in place should this have happened, as interviews have the potential to heighten participants' emotions (Mitchell, 2011). For this reason, I made it clear on the research website and recruitment material that individuals should not participate if they are likely to experience severe emotional distress when discussing abortion. I also clarified what would be discussed during interviews, and that they had the right to withdraw from the interview at any time. I obtained informed consent in both written and verbal form. I purposely asked an open narrative style question at the beginning of the interview, "[p]lease tell me about your abortion journey, in as little or as much detail as you would like. Feel free to stop or take a break at any time." This allowed participants to share what they wanted with me, and to stop or remove themselves if they required. Prior to the interviews, I spoke with the Director of Antenatal Results and Choices to gain advice on interviewing individuals who have accessed abortion. I kept this advice in mind throughout the interviewing process. If participants had become severely distressed, I would have passed the details of the MSI and BPAS counselling services on to them.

Reflective stop-off

None of the participants became severely emotionally distressed. Diana became slightly teary-eyed when discussing her experiences, but continued the conversation with ease, showing no other signs of distress. Pam reflected on how emotional she was at the time but commented that she had now come to peace with her abortion and could discuss her experiences openly. By contrast, Bao spoke about her abortion in a matter of fact, emotionless manner, focusing on the practical elements. Thus, participants displayed a range of emotions when discussing their experiences of accessing/trying to access abortion.

It was important that I had procedures in place should participants have become distressed, whilst understanding that accessing abortion does not make an individual inherently vulnerable or susceptible to emotional distress.

Anonymity and Confidentiality

Due to the stigmatised cultural context of abortion in the UK (Love, 2017; Purcellet et al., 2014) and the potentially sensitive nature of the research, anonymity and confidentiality were paramount. I gave participants a pseudonym and removed all identifiers during the transcription process. However, I informed them that:

"Confidentiality cannot be guaranteed (participants may be identifiable to a third party) due to the limited size of the participant sample and information participants may give during the interview".

I contacted one participant post analysis to confirm whether I could include her ethnicity and the country that she had found out she was pregnant in (Italy). I explained that this could make her identifiable. She was happy for me to include and publish this information.

Reflective stop-off:

Many participants commented that they had not told their friends and family. Jane stated: "very few of my friends know I have had one, let alone two. And I would never ever disclose it to a partner, or anything like that. It is like a hidden shame for a lot of people isn't it?" This highlighted her opinion on how she should feel about her abortion, and others knowing about it. Also, several participants double-checked with me over email that a pseudonym would be used, even though I had outlined this on the website and consent form, indicating that this was a particular concern for them.

In addition, I took data protection measures to ensure the anonymity and confidentiality of participants. I recorded the interviews on an encrypted device and transferred them to the Liverpool John Moores University network at the earliest opportunity. I immediately deleted the audio from the encrypted device. I stored a backup on an encrypted external hard drive. I was the only person to access the audio recordings to transcribe and listen back to them during the analysis phase.

Thanking Participants for Their Time

Initially, I did not intend on rewarding or compensating participants financially for their time. This was solely a money saving exercise, rather than an ethical commitment. However, after I experienced issues with recruitment, spoke with a research recruitment agency, and read about the recruitment techniques employed in other abortion studies, I decided to thank participants for their time with gift vouchers. On reflection, this fit with the feminist underpinnings of the research. By paying participants I acknowledged their important contribution and the vouchers acted as a symbol of gratitude (Head, 2009). I made the distinction between thanking and compensating participants, as I was not reimbursing participants for any costs they may have incurred. Instead, I chose to give a gift to them to acknowledge my appreciation, and to improve the response rate.

Specifically, I thanked participants with £30 worth of Love2shop vouchers. I contacted those who had already participated and asked if they would like to receive these vouchers. It was important that I decided how much participants should receive (Fry et al., 2006). The value of the vouchers had to entice participants without putting pressure or coercing them into taking part (Ripley, 2006), while acknowledging their contribution. However, it can be argued that it is impossible to decide on an amount based on the assumption of potential coercion, as those who fit the eligibility criteria will not be a homogenous group. Also, they have agency and free will and are not inherently vulnerable to financial coercion. Therefore, I based the compensation on suggestions from the research recruitment agency with which I was in contact, other health-related studies on the website Healthopinions.co.uk, and conversations with friends outside of academia to understand their perspectives on what constitutes a fair price. I decided that thanking participants with a £30 gift voucher was feasible in terms of the research stipend, yet still seemed fair.

I sent the vouchers to participants in the post after their interview had occurred. I made it clear on the website, recruitment material, and verbally prior to the start of the interview that participants would still receive the vouchers should they leave the interview early or remove their data from the study, and that their address would be deleted as soon as the vouchers had been sent.

Reflective stop-off:

Giving physical vouchers proved problematic. Firstly, two potential participants decided not to participate as they would have preferred e-vouchers, which was understandable as one's address is extremely personal information. Secondly, two of the participants' vouchers were lost in the post, this meant that I had to resend vouchers to those individuals. I sent subsequent vouchers via recorded delivery. To remove some of these issues in the future, I would choose to compensate participants with e-vouchers when conducting interviews that are not face-to- face.

Research Design

In this section I explore the process of recruitment, the choice of research mode and rationale, the specific research method and rationale I employed, and how this fit within a liberal feminist constructionist philosophical standpoint.

Population

The population from which I aimed to recruit from was anyone who had accessed or tried to access an abortion in the UK. This definition was open to interpretation and as a result I recruited one male participant who shared his experience of his partner accessing an abortion, as he viewed this as a joint experience. I altered the inclusion and exclusion criteria throughout the study, these can be viewed in table 4.

Recruitment

I utilised voluntary response sampling to recruit 25 individuals who had accessed or attempted to access an abortion in the UK. I recruited participants from March 2020 until April 2021. The nature of my programme of research meant participants self-selected in response to the recruitment material.

The sample size and sampling method reflected the use of semi-structured interviews and the philosophical underpinnings of the research. I could only reach a small number of participants due to time restraints. Therefore, my programme of research did not provide the generalisable account which positivist researchers seek, as it was not my intention to do so, and it would not have reflected my research philosophy (Finlay, 2006; Vishnevsky & Beanlands, 2004); instead, I opted for in-depth data over generalisable data, and rejected universal laws.

I attempted to recruit participants through NHS organisations. I contacted NHS abortion services through my supervisory team and approached abortion advisory services and sexual health services. I would have gained IRAS ethical approval had these advances been successful. However, due to COVID-19 and stretched resources, none of the organisations I contacted had the capacity to act as gatekeepers for my research. I therefore recruited participants as I have detailed in table 4.

Table 4: Recruitment process

Phase	Date	Recruitment criteria	Recruitment material	Recruiting from	Participants recruited	Additional information
1	March 2020- June 2020.	Anyone over the age of 18 who had accessed an abortion in the UK. Individuals could not participate if they abused alcohol/drugs, had a serious mental health condition, or felt they would become extremely emotionally distressed when discussing abortion.	Appendix B	Social media platforms: Twitter, Instagram, and Facebook; feminist groups (including university feminist societies); several high-profile Twitter pages that focus on abortion rights; forums targeting young	4	

				people, mothers, religious individuals, and those in the LGBTQ+ community; non-NHS groups that provide abortion services and counsellors;		
2	July 2020-Dec 2020	Anyone over the age of 18 who had accessed an abortion in the UK; individuals could not participate if they abused alcohol/drugs, had a serious mental health	Appendix C	Social media platforms: Twitter, Instagram, and Facebook. www.callforparticipants.com	0	I was concerned by the low response rate and the language used in the recruitment material, particularly the phrase ‘conscientious objection’; as although I made it clear that participants needed no prior understanding, using the phrase may have discouraged potential participants. Therefore, I altered the recruitment

		condition, or felt they would become extremely emotionally distressed when discussing abortion.				material to make it more comprehensive and precise.
3	Jan 2021	Anyone over the age of 18 who had accessed an abortion in the UK. Individuals could not take part if they abused alcohol/drugs, had a serious mental health condition, or felt they would become extremely emotionally distressed when	Appendix D	Social media platforms: Twitter, Instagram, and Facebook. www.callforparticipants.com	6	I considered outsourcing my recruitment using a research recruitment company. However, this process would have been extremely costly. I was quoted £3,300 for the recruitment of 30 participants. Instead, I decided to give a financial incentive of £30 Love2Shop vouchers. It would have been preferable to have compensated Participates with a bank transfer; however, I could not do this for tax reasons.

		talking about abortion.				
4	Jan 2021-April 2021	I altered the inclusion criteria to belonging to one of the following: 1. Tried to access/accessed abortion in NI. 2. non-cisgender individuals who have accessed abortion in the UK. 3. Attempted to access abortion in the UK but were refused for a non-medical reason. 4. Experienced a healthcare	Appendix C, D, E	Facebook paid advertising (£140 - targeting women on Facebook between 18 and 65), www.callforparticipants.com, and Reddit, LGBTQ+ groups on Instagram and Facebook	15 (all from www.callforparticipants.com).	I was reassured by the impact the financial incentive and the new advertising material had on the number of potential participants coming forward. However, only one of these individuals had experienced conscientious objection, and none of the participants had accessed/attempted to access abortion in NI.

practitioner refusing to participate in their abortion for a non-medical reason. 5. Experienced an abortion referral to another healthcare professional for a non-medical reason.

I collected demographic information from the participants when they signed the online consent form. During the first three interviews, I obtained this information at the beginning of the interview. However, this interaction was somewhat awkward and meant that participants may have felt obliged to answer these optional questions. Hence, I introduced the self-report form depicted in Figure 2 on the research website to be completed prior to interview.

Figure 2: Participant demographic form

Name

Email

I agree to the above statements.

Age

Gender Identity

Religion/Non-Religious

Occupation

Location

Ethnicity

Submit

The participants ranged in age from 21 to 54 years old, and in terms of ethnicity comprised the following: thirteen White-British, one British, one Nigerian, one Italian, one Chinese, one Afro-Caribbean, two British-Asian, four Black, and one British-Caribbean participant. Twenty-four participants identified as female, and one participant identified as male (Harshil), as he was speaking on behalf of his wife. He did not specify why she did not participate when I asked him. To present a plethora of views and experiences, I intended to recruit participants from varying social groups, rather than solely recruiting middle-class white women. This is especially important within feminist research (DeVault & Gross, 2012).

I give a detailed breakdown of participants' demographic characteristics in table 5:

Table 5: Participant demographics

Pseudonym	Age	Age when aborted	Occupation	Location of Abortion	Religion	Ethnicity
Kathy	36	16	Youth worker	London	Born Again Christian	White-British
Holly	51	30	Midwife	Urban North England	Buddhist/Protestant	White-British
Amy	.	19	Nursery practitioner	Urban South England	Christian	Nigerian
Nadia	29	17	Nursing student	Urban North England	None	White-British
Tia	24	16	Educational mental health practitioner	Urban North England	None	White-British

Jane	54	18,28	Midwife	Urban North England	None	White-British
Maria	26	24	Teaching assistant	London	None	Italian
Pam	33	.	PA	Urban South England	None	White-British
Bao	23	22	Animator	Urban Midlands England	Buddhist	Chinese
Sarah	39	.	Prison officer	Rural South England	Christian	White-British
Diana	53	16	Student counsellor/Support line manager	Urban North England	Anglican Catholic	White-British
Elise	36	.	Event manager	London	Christian	Afro-Caribbean
Dani	20	.	Student nurse	Urban North England	Spiritual	White-British

Aisha	47	34	Unemployed	Rural Midlands England	Islamic	Asian-British
Katie	23	22	Unemployed	Urban Wales	Christian	Black
Ashley	26	.	Self-employed	London	Catholic	British-Caribbean
Janie	24	.	Homemaker	Urban South England	Christian	Black
Lauren	42	.	Operations manager	London	None	White-British
Harshil	27	23	.	London	None	British-Asian
Rosanna	21	.	Customer services	Urban North England	Christian	White-British
Emma	21	18	Student	Rural South England	None	British
Jess	34	25	Unemployed	Urban South England	Non	White-British

Jennifer	25	.	Supplier	London	Christian	Black
Keeva	30	30	Waitress	Rural Northern Ireland	Christian	Black
Charlie	38	38	Art therapy support worker	London	None	White-British

Interview Modes

I created a framework to use when deciding what interview mode to utilise (Self, 2021). I developed this using Oltmann's (2016) model to include VoIP, as well as telephone and face-to-face interviews. Within this framework I focused on the context surrounding the interviewer and the participants. In the following section, I use this framework to outline the pros and cons regarding the choice of interview mode.

Before the COVID-19 pandemic I gave participants the option to interview over the telephone, face-to-face, or using VoIP, after carefully considering the researcher's and participants' particular contexts (Self, 2021). During the pandemic, I removed the option to interview face-to-face to abide by government restrictions and laws and to keep participants and myself safe. Therefore, because I only conducted telephone and VoIP interviews, I focus on the benefits and limitations of using these.

Those who have accessed abortion are often stigmatised and may feel awkward discussing their experiences, as abortion can be (but is not always) a sensitive topic. It is argued that it may be difficult to discuss such topics face-to-face (Carr & Worth, 2001). However, telephone and VoIP interviews may have reduced the perceived awkwardness of discussing abortion due to the increased physical proximity between the participants and myself (Bayles, 2012) and the perceived anonymity (Sturges & Hanrahan, 2004; Sweet, 2002). This anonymity increased over the phone, or by turning off the video streaming function during VoIP interviews, as I created the 'faceless researcher' effect. Janie asked to turn her video off after I had explained the interview process, and I followed suit. This indicated that she felt more comfortable conversing without our faces visible. However, Dani chose to turn her video streaming on, commenting that it felt more personal. Thus, it was evident that there were large individual differences between participants.

Moreover, it is argued that participants are more open and expressive when interviewing over the phone and using VoIP (Deakin & Wakefield, 2014; Gray et al., 2020), as they can relax in their own environment (Gray et al., 2020). Maria and Rosanna mentioned that they were not at home for fear of being overheard; this caused minimal distractions and was not problematic. The fear of being overheard may have been exacerbated for those living with others, particularly over periods of lockdown and when the furlough scheme was in place (Self, 2021). However, in comparison, face-to-face interviews are often viewed as more invasive as the researcher usually travels to the participant and interviews them at home, work, or a public space close to home (Whale, 2017).

In addition, participants had the flexibility to re-arrange interviews if the time no longer suited them and schedule interviews around their pre-existing commitments (Novick, 2008). Therefore, telephone and VoIP modes gave the participants more control over the research process (Cheng, 2018; Novick, 2008; Sweet, 2002). As I used these modes the obvious benefits of: reducing the time and financial costs (Archibald et al., 2019; Carr & Worth, 2001; Gray et al., 2020), and widening the geographical spread of participants (Archibald et al., 2019; Gray et al., 2020; Oltmann, 2016) were clear. This was particularly useful as I was able to recruit participants from rural and urban areas in NI, Wales, and England. However, employing these modes meant that I could not study non-verbal cues as easily (Bayles, 2012). I focused mainly on what participants had to say. I identified the way in which they expressed this by listening to auditory cues, their tone of voice, pauses in speech (Opdenakker, 2006), wavering of voice, and their facial expressions via VoIP (Seitz, 2016). Regrettably, I could not observe facial expressions over the phone or when participants chose to turn off the video function when using VoIP. Overall, I felt that I could gauge participants' emotions and react to them sufficiently, though this may have been easier face-to-face.

Although I could have experienced technological issues (Carr & Worth, 2001; Deakin & Wakefield, 2014), fortunately these were minimal. Harshil had issues using Microsoft Teams, so we switched to Zoom. Both Keeva and Aisha struggled with their Wi-Fi signal during their VoIP interviews. This affected the sound and picture quality, and as a result I had to repeat some of the questions which wasted time and interrupted the flow of the conversation. More importantly, one participant struggled with some of the questions in the latter section of the interview as they had to navigate the complex and philosophical nature of conscientious objection in a second language. This impacted the flow of the conversation and as a result I had to repeat questions. Although the sound and picture quality were not ideal at times, I used the chat box function to repeat or explain the questions. If I had written questions down in a face-to-face interview this may have proven awkward. However, using the chat function on VoIP had been normalised at this time and was a useful addition. The benefits of using telephone and VoIP platforms outweighed the technological problems, as noted by Archibald et al. (2019).

Finally, it is important to reiterate that I was interviewing in the context of the COVID-19 pandemic. At that time, VoIP had become ingrained in all elements of our society, including teaching, medicine, worship, law, and therapy (Self, 2021). Kominers et al. (2020) went as far to say that Zoom was central to society during the pandemic. This growth in VoIP created a more intergenerational, globalised, 'tech savvy' society. This was supported by online guides and tutorials instructing the general public on how to use VoIP. Participants and researchers were therefore more likely to have an adequate internet connection and technological understanding (Self, 2021). Thus, they may have been more willing to participate in research using VoIP, as they felt more relaxed and familiar with technology (Self, 2021). Also, they may have felt more comfortable letting strangers 'enter' their home through the lens of VoIP, as this practice was normalised in 2020/21 when various professionals (such as therapists and doctors) operated over VoIP (Self, 2021). Despite these societal and technological changes, it was important that I did not romanticise the impact of the increased use of VoIP, as although the majority of individuals embraced it, this was not the case for everyone (Self, 2021).

Hybrid Interview Approach

I chose to employ a hybrid approach to combine the benefits of both narrative and semi-structured interviews. These approaches complemented the research questions. In the first part of the interview, I adopted a narrative approach, whereby participants shared their abortion journeys and any experiences of conscientious objection. I used the data generated to answer the first and second research questions: 1. What are the abortion journey experiences of service users in the UK? 2. Have conscience clauses in abortion legislation affected UK service users' reproductive rights regarding access to and experience of abortion? In what ways? In the second section of the interview, I focused on participants' views of conscientious objection and employed a semi-structured approach. I used the data to answer the third and fourth research questions: 3. What do service users understand as constituting 'participation in abortion'? 4. How do service users situate themselves regarding Wicclair's (2011) three-part framework? I developed the interview schedule once I had conducted my systematic literature search. It was therefore informed by existing literature and Wicclair's (2011) three-part framework. The interview schedule can be found in Appendix A. I discussed the interview schedule with my supervisors, colleagues, and friends (lay persons), two of whom had accessed abortion. I then piloted the interview with two friends who had accessed an abortion. I altered the interview schedule in line with their feedback, I removed some of the interview questions and simplified others.

Narrative Interviews

Narrative interviews allow the participant to tell a story and present their lived experiences (Kartch, 2017). This notion captured the core aims and theoretical framework of my programme of research regarding listening to the voices of women and individuals who can become pregnant. If I had utilised alternative methods such as surveys and structured interviews participants' exploration of their experiences may have been stifled due to the in-flexible nature of these methods (Clark et al., 2021). Thus, participants were able to voice their own experiences.

Moreover, narrative interviews do not adopt the traditional question and answer format. Instead, the participant leads the interview by sharing what they feel is important with regard to the open-ended question posed, meaning they are able to decide where to start their story and the flow of the topics (Jeong-Hee, 2016). To initiate the interview, I posed the statement: "please tell me about your abortion journey in as little or as much detail as you would like, feel free to stop at any time". As a researcher, I aimed to listen rather than interrupt, asking questions only when the participant stopped telling their story (Jeong-Hee, 2016).

Semi-Structured Interviews

I utilised semi-structured interviews in the second section of the interview to gauge participants' views on conscientious objection. It was important that I used a semi-structured interview rather than narrative/unstructured approach as many participants had no prior knowledge of conscientious objection and it was important to gather their views on a range of specific topics relating to conscientious objection to answer the research questions. Moreover, as I used a semi-structured format participants were able to share viewpoints that I had not considered (Clark et al., 2021) and I could follow up on interesting insights (Fylan, 2005). It was evident that semi-structured interviews form a 'natural extension' of the participants' worlds and constitute a social practice as well as a research tool, as I organised the interviews in order to take a conversational and dialogical approach (Kvale & Brinkmann, 2014). I was able to question service users' responses in greater depth and resolve apparent contradictions, something that would not have been possible using quantitative methods (Horton et al., 2004).

Reflective stop-off:

The following conversation I had with Holly demonstrates how I questioned contradictions within the interview process:

“Becky: […] So what elements of the abortion process do you think you should be able to object to then?

Holly: Anything you want.

Becky: So, that may contradict your definition of participation as hands on. Because if you see participation as hands on, and law states you are able to object to participating. It’s then limited in the eyes of the law.

Holly: So yeah, ok. So, I consider the actual demise of the foetus, like you know, the foeticide, injecting potassium. But not the delivery. And that is not something that one person is ever deciding, it’s a, you know, team approach.”

However, although I was able to question contradictions, this may have made participants feel like they had answered incorrectly. I soon discovered that many participants gave answers that contradicted something they had previously discussed. This highlighted the complexity of conscientious objection. I therefore had to be tactful with regard to what contradictions I questioned, as I wished to prevent participants becoming uncomfortable and feeling challenged.

Moreover, semi-structured interviews are described as particularly useful when studying individuals’ perceptions and views of complex topics, as a discourse can be created around the subject area, ensuring participants understand the questions and have the opportunity to elaborate on their standpoint (Barriball & While, 1994). Thus, by employing semi-structured interviews I increased the rigour of the research, as I ensured that participants understood the topics being discussed and the nature of conscientious objection. I asked participants to articulate their understanding of the phrase conscientious objection before giving the following definition, regardless of their prior knowledge: “conscientious objection is the refusal to participate in an activity that an individual considers incompatible with their religious, moral, philosophical, personal, or ethical beliefs". It would have been challenging to have a discussion with participants about their understanding of conscientious objection using survey methods, and participants may have been embarrassed to ask questions to develop their understanding of conscientious objection in a focus group setting. Thus, by using semi-structured interviews I increased the credibility of the research, this method proved fruitful in studying participants views on the complex topic of conscientious objection.

Benefits of Both Semi-Structured and Narrative Interviews

Semi-structured interviews and narrative interviews are seen as an appropriate format for discussing sensitive topics (Fylan, 2005). Abortion is not always a sensitive topic but can be for some. If I had utilised questionnaires, participants may not have realised that they had no obligation to complete the questions, or even to take part at all. Participating in questionnaires may have had adverse effects on participants' well-being and could have caused emotional distress. Participants may have found it equally distressing/uncomfortable discussing their abortion experiences during an interview. However, I utilised a hybrid approach this meant that participants could share what they felt comfortable sharing and I was able to explain to them that they had the right to withdraw and could take a break at any point. Also, I could signpost participants to counselling services after the interview and answer any of their questions to give further information or resolve any misunderstandings when necessary (Fylan, 2005). I deemed focus groups inappropriate as participants may have felt uncomfortable discussing their experiences with others in a group format (Adams, 2015). In addition, logistical issues relating to arranging focus groups at a time suitable for all participants would have potentially impacted recruitment and attendance.

I choose this method to reflect the ontology and epistemology. Semi-structured interviews and narrative interviews are qualitative. By employing them, I rejected positivism and the practices and norms of the natural scientific model, as positivist methods undermine the complexities and indeterminate nature of social life (Blumer, 1969). I utilised interviews to align the method with a view of social reality as an emergent, constantly shifting property created by individuals (Bryman, 2008). Individuals were able to share their views of reality during the interviews, which allowed for a better understanding of their opinions, views, and actions (Lather, 1991). Moreover, feminist researchers no longer favour qualitative methods over quantitative methods, instead the method employed is assessed in relation to the research questions rather than a particular preference for qualitative or quantitative research (Jenkins et al., 2019). Gurr and Kelly elaborate on this, stating that methods themselves are not feminist, rather it is the methodological approach that is feminist (Green, 2020).

Limitations of Semi-structured and Narrative Interviews and Overcoming them

An obvious limitation when utilising both narrative and semi-structured interviews is the skill set of the interviewer (Clark et al., 2021). Findings vary considerably, depending on the questions asked within semi-structured interviews and the rapport built. I therefore felt it was essential to build a rapport to ensure each participant was comfortable enough to share their experiences of abortion. However, it was important that I remained aware of the possibility of becoming too casual, as I needed to strike a balance between listening to the participant’s story and probing (Charmaz, 2001). My previous training at the University of Warwick and the University of Oxford, as well as my research roles provided me with the skill set required for undertaking interviews. I was able to create a rapport while gaining relevant information. I shared the pilot interview transcripts with my supervisors and colleagues to elicit feedback on my interviewing technique. This, alongside training, ensured I had the relevant skill set to conduct the interviews.

Another limitation of narrative interviews is that some individuals find it difficult to share information without being asked questions (Anderson & Kirkpatrick, 2016). For instance, in my programme of research, some participants found it challenging to discuss their abortion journey in the style of a monologue. I adapted the approach for said participants and I asked questions; this narrative section took a more semi-structured nature.

The Case for not Using Case Studies

Initially, I intended to follow up the interviews with a subsequent phase of interviews with three to five participants. I gained ethical clearance for this. I would have selected these participants if they had experienced conscientious objection, or their experiences or views contradicted previous findings. I would have used this data to create individual case studies for each participant in this phase.

By using case studies, I would have gained an in-depth holistic understanding of participants' abortion journeys. It would have helped to give the reader a sense of "being there" by providing a highly detailed, contextualised analysis of "an instance in action" (Macdonald & Walker, 1977, p. 182). However, once I familiarised myself with case studies, focusing particularly on the work of Yin (Yazan, 2015; Yin, 2009), I became dubious as to whether they were the best choice of research design. Firstly, I learnt that case studies are usually formed of multiple data sources which can include: interviews, archival records, documents, direct observation, physical artifacts, and participant observation (Rowley, 2002). Initially, I envisioned that data would consist of two sets of interviews, the first would have been those I have presented in this programme of research, and the second a series of follow-up interviews to gain more depth. It was evident that I needed more data sources. I decided to include written accounts, life-history timelines, and social network diagrams. However, after deliberation I questioned how such additional data would contribute to the research aims and objectives. It seemed that the collection of life timelines and social networks would have proved fascinating and would have provided more data for the creation of case studies but would not have contributed to the aims and objectives as the data would not specifically encompass conscientious objection or accessing an abortion. For this reason, I choose to present all participants' experiences individually and holistically (as a whole narrative with context) using found poetry (McCulliss, 2013). This provided context for the feminist thematic analysis and was data in its own right.

Feminist Methodology

In the following section, I outline the principles I adopted from feminist methodology, and feminist interviewing in particular. My main influence was Oakley's (1981) seminal piece on interviewing mothers before and after childbirth, as well as the work of Kelly (2020) and Acosta (2020). Oakley (1981) critiques the then contemporary ‘masculine models’ of social research interviews, as she deems them symptomatic of the marginalisation of women’s experiences in sociology and society. Instead of remaining stern and detached, Oakley reframes the role of the researcher as involved in a two-way social interaction with personal meaning. Kelly (2020) and Acosta (2020) build upon these principles to develop a contemporary guide to conducting feminist research.

Sharing Myself

The first principle I adopted was the notion that I have labelled ‘sharing myself’. Oakley (1981) described that she shared her own personal biography by answering participants’ questions. Acosta (2020) also shared her own experiences with participants and increased her online presence by blogging, creating a research website, and sending her personal social media accounts to participants to share her family’s background before they shared their own in the interviews. Sharing oneself can be important when building a rapport, particularly when using ‘faceless’ research modes such as telephone interviewing (Acosta, 2020).

Reflective stop-off:

I initially questioned how much I should talk about myself, and my opinions of conscientious objection, as I did not want to sway the participants’ views or lead them to agree with my own perspectives. I bore this in mind and shared my views when I agreed with what the participants had already stated or when they asked me directly.

Moreover, I gave my own opinion and elements of my identity to build a rapport with participants and to further the discussion. Notably, Pam asked me directly if I wanted children. I explained that I have chosen to remain childfree. We had the following conversation around this:

“Pam: Sorry, if you don’t mind me asking, do you have kids?

Becky: No, no, I don't want kids personally […]

Pam: It’s quite refreshing to hear that you know, because you don't often hear it really. From females, so.

Becky: Yeahhh, it's quite funny actually. 'cause me, my friendship circle, there about of five of us. Three of us don't want kids, and we’re quite adamant that we don't want kids […] 'cause then when you’re with someone, stereotypically you always think it's the woman who wants the kids. But in my experience, I've always been with people and they've wanted kids, and I haven't. And it has - even though I'm only 27 - it has. It has kind of put up a barrier, for some relationships going further.

Pam: Ohhh yeah. […]that's kind of how I feel. I’m glad I know that from you. Because that’s deep down how I feel. So it's nice to know I'm not the only one”.

It was evident that Pam was interested in my opinions and those of my friendship group, as they differed from her own experiences. She saw this perspective as refreshing and it seemed to validate her own life choices around remaining child-free, and potentially around accessing abortion. Pam also joked that I should be asking her the questions, and that it felt like she was interviewing me. This interaction and process of sharing myself not only helped create a rapport, but also helped to challenge the researcher-participant power dynamic.

In summary, sharing my own identity and views created a rapport and re-established the interview as a dialogue between two individuals, rather than a one-way process where the researcher investigates the participant. This informed the next principle of co-creating meaning.

Co-creating Meaning

I embraced the feminist constructionist ontological underpinnings of my programme of research by co-creating meaning when I undertook the interviews. Feminist constructionism, in the same way as social constructivism, posits that there is not one constant social reality; instead, humans construct multiple versions of reality (Clark et al., 2021). This rejects outdated positivist notions of interviewing which situate the researcher as an objective tool for gaining information rather than an active participant in the information creating process (Oakley, 1981). Thus, when interviewing, a version of reality and identity is constructed by the researcher and participant that forms the research data (Heaton et al., 2015).

Reflective stop-off:

Although all elements of the interviews can be seen as co-created, discussions of conscientious objection displayed obvious co-creation, as not only did we discuss experiences and views, but participants formed views within the interview process. This was particularly evident when I explained Wicclair's (2011) three positions, as many participants had not considered a middle-ground approach. The following conversation exemplifies this:

“Becky: Do you think that healthcare practitioners should have the right to object to participating in abortion?

Tia: Oh God. I don't know. I'm really torn, because obviously I'm not religious, sooo it's really difficult erm… I guess if you’re getting into that profession, you've gotta be open erm.. to anything really. So I think you kinda gotta put that to one side sometimes. Erm, but unless you kind of stated when you come into the job, you know. I am objecting from this moment, and not just on individual cases. Sooo erm, I guess - I'm not sure if you're a nurse. Don't go into abortion, if you, if you're gonna specialise in that area. So, I think you should have the right to be able to say no, to whatever you disagree with. But obviously I'm kind of er, pro-choice so… it's really. I'm quite biased. So I'm probably not the best person to ask. Then, but if I had to say yes or no. I think that, it should, it shouldn't influence your practice.

[…]

Becky: there's kind of three main perspectives in the literature. So you've got like the one that basically says no one should be able to object, if you go into that profession, you do the job. Then you've got the other end of the scale where they say, if you're in the profession, you should be able to object to anything you don't want to get involved in, you don't have to refer them on, you don't have to give them any information. And then you've got the middle-ground, which is, um, you can object. But then you have to refer them onto someone who will take over, and they will get the care they need.

Tia: Ok, I agree with that. I'm very middle-ground then.

Becky: yeah, yeah.

Tia: 'cause I think like, as an employee. If there was something I came across, say in mental health. You know, there's a lot of sensitive topics. If I was not comfortable with that, and I've got colleagues, you know that just referred on."

Further, when concepts and questions did not align with participants' experiences, they created their own views during the interview.

“Charlie: Erm I think, we're in the UK, like we're in a position where, we can withhold, we can have, we can hold people who, object because there's enough options there for women, to find alternatives. But I think. I don't know. I honestly don’t know. I've never even thought about it before to be honest, 'cause I I think 'cause I've had such a… I I'm not gonna say positive, because because I was satisfied with how things went. I've never really looked at the other. I've never really thought about women who couldn't, get anything from their GP 'cause that did not happen to me.”

However, although meanings are co-created within the interview process, this is not free from the researcher-participant power dynamic. Researchers ultimately have an agenda and topics of interest, meaning participants are not in full control of the research process (Jenkins et al., 2019). Thus, I did not romanticise the extent to which participants were empowered in this process, as I also needed to consider power hierarchies and structures.

The Friendly Stranger

Feminist interviewers should remain friendly, warm, and compassionate (Oakley, 1981). This allows the researcher to build a rapport while making the participant feel conformable. In Oakley's (1981) account, she used friendliness as a method for challenging the masculine principles of qualitative research. However, questions have been raised whether this principle serves the researcher or the participant, as building a rapport and emotional trust can be seen as a ‘fake friendship’ which is used to encourage the participant to open up and provide information for the researcher (Kirsch, 2005). This has been presented as problematic because the participant may share information they later regret sharing, or develop negative emotions such as mistrust and disappointment, especially if a ‘friendship’ ends abruptly (Kirsch, 2005). Moreover, researchers should differentiate between friendship and friendliness in an attempt to ethically situate their relationship with the participants (Kirsch, 2005).

Reflective stop-off:

Unlike Oakley (1981), I did not see the potential for a friendship to spawn from the interviews. I perhaps need to make the distinction between my one-off telephone/VoIP interviews and Oakley's longitudinal interviews in participants' homes. Instead, I adopted a similar approach to Cotterill (1992), as I envisioned that participants would view me as a 'friendly stranger' to whom they could open up in an environment removed from their own social group, rather than a potential friend. I made my position as a researcher rather than a friend clear by communicating using my university email and remaining professional.

Interviews as Therapeutic

A debate has occurred as to whether qualitative interviews can or should be therapeutic for participants. Those who argue that interviews are inherently therapeutic do so on the grounds that they have similarities with counselling sessions, in that they can be healing and allow participants to create meaning (Gale, 1992), cathartic (Hutchinson et al., 1994) and can allow emotional release (Rossetto, 2014). They also enable participants to better understand and contextualise their situation, which can lead to resolution (Drury et al., 2007).

Reflective stop-off:

In the same way as Rossetto (2014) and Perry and Bigelow (2020), I found that participants actively commented on the therapeutic benefits of participating in the interview; for example, Jess stated: "It's actually nice to talk about it... It's been nice to sort of get it off my chest. So thank you. You've been like a counsellor".

On the other hand, it is argued that qualitative interviews are designed to obtain information from participants rather than aid them therapeutically (Targum, 2011), and if interviews are conducted poorly they could harm the participant or researcher, rather than have a therapeutic benefit (Cramer, 2020).

Moreover, it was not my intention for the interviews to be therapeutic. Nevertheless, I did use methods that have been considered to increase the therapeutic potential of interviews to build rapport and make participants feel comfortable. I acted non-judgementally, empathetically, respectfully, and as an active listener who did not offer advice or interrupt. I also used back channel cues such as murmurs of agreement, nods, and smiles (Rossetto, 2014). It was not my intention for the interviews to be therapeutic, as individuals vary and have different agendas for taking part in research, and not all abortion service users require therapy. Also, I am not a trained therapist (Cramer, 2020) and it would have been inappropriate for me to treat the interviews as a counselling opportunity. I made this evident to participants at the outset as I made my position as a social researcher clear and provided signposting for professional counselling services on the research website.

Power

Narrative interviews have been mislabelled as inherently emancipatory and empowering due to their format and research assumptions (Love, 2017). It is argued that power dynamics between the researcher and participant are broken down, which has been synonymously labelled as 'giving voice' to participants. Whilst these methods can break down the researcher-participant power dynamic to some extent, it cannot be assumed that this dynamic has been fully achieved, as social research carries with it the expectations of the researcher (Jenkins et al., 2019). Furthermore, the research process, analysis and conclusion are controlled by the researcher and there is no guarantee of an emancipatory outcome (Jenkins et al., 2019) as the research may not facilitate social change. Moreover, the notion of 'giving voice' assumes participants need the researcher to be heard and to voice their experiences and views which is not always the case.

Reflective stop-off:

Jess's comments seemed to support the claim that interviews (particularly narrative interviews) can be emancipatory and give voice to marginalised individuals:

"I'm quite happy to talk. I mean, it's something that's been on my mind for a while… I've just never really found the right platform to do that."

Although Jess held this opinion, I cannot be assume that this was true for all participants, as although I provided a platform for participants to be heard in the policymaking process, it was not the only platform that allowed them to express their views and experiences. For example, Laura commented that she spoke openly about her experiences of abortion in public settings, including self-help groups and television interviews. Thus, Laura already had access to platforms to share her experiences and to make a difference.

Instead of embracing the paternalistic assumption of researchers 'giving voice' to marginalised populations (Cornwall, 2003), I reframed the power dynamic as participants giving their time to me on a platform I had provided, as without their willing participation, I could not have completed the research. I found myself reliant on potential participants, as there was a period of six months when no participants came forward. Despite the issues around power and emancipation, I focused on listening to service users' experiences and understandings; this did not, however, automatically empower those who participated.

It is also important to analyse the positionality of the researcher in relation to that of the participants when considering the power dynamic (Tang, 2002). Oakley (1981) originally argued that female participants and researchers are in a similar subordinate position within society, which leads to the formation of friendships due to a shared understanding. This was analysed as a shared position of power, or lack of power, within society. However, this analysis was disputed by Phoenix (1994), as Oakley failed to apply an intersectional approach. Oakley (1981) did not acknowledge the differences between women such as class, age, and ethnicity and the implications these have for power and for lived experience. She also polarised gender, focusing on stable categories of 'male' and 'female', thus ignoring those outside of the gender binary, although this was symptomatic of interpretations of gender at the time. Oakley (2016) later retracted this position, agreeing with Phoenix (1994) and commenting that her previous interpretation was naïve and lacked intersectionality. It was evident that I needed to go further than gender when analysing power. I achieve this in the following section, as I present my position within the research.

Reflexivity

I situated my programme of research within a feminist constructionist ontological paradigm. I perceived knowledge as a product of researcher-participant interaction, and as historically and contextually grounded (Finlay, 2002; Jenkins et al., 2019). My own preconceptions, identity and education inevitably impacted upon on all stages of the research process. I have already discussed how my ontological and epistemological assumptions developed and impacted the research design. In the following section I focus on elements of reflexivity which I have not discussed elsewhere. I differentiate between positionality and subjectivity (Whitson, 2017). In the positionality section I shed light on my own experiences in relation to those of the participants, in the subjectivity section I highlight my own emotional reactions to the research, I indicate my thoughts and feelings during the research process. I kept a reflexive diary throughout the programme of research to aid this process.

Positionality

Rather than claim a ‘master status’ (Cousin, 2010) where I focus on specific elements of my identity (for example gender) and label them stable and overarching, I used experience as the basis of my reflexivity. I do not reject the notion of categorising oneself as a starting point when being reflexive, as it allowed me to acknowledge the ways in which social processes and institutions have shaped my identity (Cousin, 2010). However, solely focusing on these categories does not indicate how individuals within these categories differ, not just on an intersectional level, but due to a person’s knowledge and experiences. However, I do not go as far as to adopt Cousin's (2010) concept of ‘vicarious experience’. I believe this is problematic, as it assumes we can understand others’ situations and live in their shoes through the process of reading and textual experience. This ignores the lived emotional impact of societal power dynamics, as no matter how much we read, we cannot fully understand lived experience and oppression. In fact, it is dangerous to assume we can speak with authority and knowing on an emotional level after gaining textual experience. It also ignores the way in which participants view the researcher as an outsider based on difference. In the following section I discuss my personal experiences and how these influenced my interactions with participants.

Firstly, my own experiences differed from those of the participants as I have not had an abortion or tried to access abortion. This ultimately positioned me as an outsider. My outsider status was unknown to participants and was not questioned due to its potentially sensitive nature. For instance, Diana commented:

“I don't even know if you, if you've had an abortion or not, it's absolutely none of my business. But what I'm trying to say is, unless you have, you have no idea of the level of guilt that a woman feels with it anyway.”

I deliberately did not disclose whether I had had an abortion, as I did not want Diana to feel judged, or that she could not share certain details of her experience with me. I also did not challenge her generalisation of all service users’ emotions, as I did not wish to create friction and delegitimise her own experiences and emotions. However, as I am female, she may have assumed that I could have, or had, accessed an abortion. I therefore adopted the role of an unknown outsider. This meant that I could not self-disclose in an act of ‘reciprocity’ as a way of creating a rapport and putting participants at ease (Oakley, 1981). However, I was not in the disadvantaged position of inadvertently making erroneous assumptions based on my own lived experiences as an insider may have done (Hewitt-Taylor, 2002). It is argued that insider familiarity can create an ‘illusion of sameness’ (Pitman, 2002). Thus, as I adopted the position of an unknown outsider my judgement remained unclouded (Innes, 2009).

Moreover, it is argued that there is a significant level of difficulty involved in conducting research as an outsider (Horowitz, 1983). For example, Chawla-Duggan (2007) discussed how she struggled to gain access to participants and faced hostility as she was culturally an outsider and therefore considered a foreigner. I did not find this problematic, as although participants came from a range of ethnic backgrounds, there was a shared status of living in the UK and there was no obvious focus on researching culture, or a specific cultural group. Also, as I utilised 'faceless' recruitment methods and research modes (telephone and VoIP without video streaming) I could hide my ethnicity, which could have altered participants' experiences. I cannot postulate how individual participants felt talking to a white researcher, particularly about matters such as race.

Moreover, Ashley discussed her identity as a woman of colour, and how this impacts her day-to-day experiences, particularly in the context of healthcare. Within these discussions I was an obvious outsider, as I conducted this interview over Zoom, this meant Ashley could see I was a white woman. I understood Ashley's experiences as I have read widely and have had discussions with non-white friends about systemic and institutional racism. Cousin (2010) would argue that this places me in an advantaged position of knowing through vicarious experience. However, I have not experienced systemic racism first-hand. I have been angered by my friends' experiences, and what I have read, but this does not impact my livelihood, position in society, and emotions to the same extent. Thus, when we discussed these issues, Ashley could have quite rightly felt that I was an outsider. Despite this, she shared emotional, in-depth, and fruitful experiences and views on how race intersects with gender within healthcare.

On the other hand, there were times when I shared 'insider moments' (May, 2014) with participants, despite being an outsider. For example, Diana and I bonded over the fact that we both identify as feminist, as I explained how feminism underpins my programme of research and is a big part of my life.

Diana: ... “I think it's because I come from that feminist angle as well. So I I really do believe that it is another way of controlling women, and and the power over the bodies and that. That's why I think I'll always have that. That kind of view.

Becky: Yeah, yeah, […] 'cause obviously I'm a feminist myself - and I'm doing my research from a feminist perspective. And when I analyse…

Diana: Good for you.

Becky: Oh my little bookshelf down there is stacked with feminist lit. But well, yeah. When I analyse I'm going to use a feminist framework. Uhm, as well as a thematic analysis. So themes with a feminist lens. Erm and yeah, I think it's just important to get that side of things across.

Diana: Absolutely. Because I'm telling you now it is. It's all about control. It's all about control over a women, and you've got a lot of women remember. So for example, the midwives, a lot of women are gatekeepers to the patriarchal society anyway, and they enable it.”

Moreover, I acknowledged the similarities and differences between the participants and myself, and the impact this had throughout the research process.

Subjectivity: Understandings and Views of Conscientious Objection

As well as positionality, subjectivity impacts the research process (Whitson, 2017). I noted my views on conscientious objection in a reflexive diary throughout, this enabled me to understand how my stance on the research topic evolved. This is a technique that I borrowed from the research tradition of Gadamerian Hermeneutics (Fleming et al., 2003). Before reading any literature on conscientious objection, I took a zero-sum approach (Campbell, 2011) where building on my feminist background I labelled all conscientious objection as a barrier which prevents service users from accessing abortion.

I believed conscientious objection must have an emotional impact on service users, even in the referral process, as a healthcare professional would be actively or invertedly pushing their disdain for abortion onto the conscience of service users. I believed this could have an irreparable impact on service users' decisions and mental well-being. Although I understood the impact this must have on healthcare professionals and their freedoms, I labelled these as secondary to those of the service users. This opinion was strengthened by conversations I had with a friend who worked on an international research project focusing on conscientious objection. At this stage, I failed to differentiate between conscientious objection in the UK and elsewhere, discussing it as a homogenous issue. These views led me to the work of Fiala and Arthur, Savulescu, Schuklenk, and Smalling.

After reading copious amounts of literature, I came to the conclusion that conscientious objection is not necessarily anti-feminist as it is not a zero-sum phenomenon (Campbell, 2011) and that conscientious objection should be allowed to protect the human rights of healthcare professionals. However, I treat this with great caution as I still believe conscientious objection is thwart with issues and that regulation is necessary. Once I began interviewing individuals who had experienced conscientious objection, it strengthened my views on a form of regulation as some participants had not been treated in line with guidelines, this left these service users vulnerable, and in some cases, they did not know where to turn. I found this highly problematic, favouring an approach where objecting healthcare professionals do not have to come into contact with service users seeking abortion. Minerva's (2015) ratio approach appealed to me, as this contact would be removed. However, I believe it is not without problems as it assumes a black-and-white form of objection and a workforce that can easily move geographically, not to mention the financial costs of such a system. I maintained this opinion of conscientious objection throughout the remainder of the research, the analysis, and writing-up process.

Moreover, my opinions on conscientious objection inevitably impacted the research process. Firstly, I framed the research questions and aims from the perspective that conscientious objection may be negatively impacting service users. This was evident in my question: Have conscience clauses in abortion legislation affected UK service users' reproductive rights regarding access to and experience of abortion? In what ways? The potential impact of conscientious objection is extremely apparent to me, meaning this question was integral to the research. Other researchers may have placed less emphasis on experience and more on the views of those who have accessed abortion and not experienced conscientious objection, as this is a much easier group to recruit from. Evidently, my subjectivity also impacted the recruitment process, as I wanted to gain a plethora of experiences and views from those who had experienced abortion and conscientious objection. For this reason, I decided to focus my recruitment material on those who had issues accessing abortion and those who had accessed or tried to access abortion in NI.

Nevertheless, despite my own views and subjective position on conscientious objection, I framed the interview questions around existing literature and used examples such as the Doogan and Wood case. I also refrained from asking leading questions. For example, when discussing auxiliary tasks I asked Charlie, "should they have to do those things for the smooth running of the service, or is there someone else that can do those?" instead of asking, "should healthcare professionals have to carry out auxiliary tasks?" I removed some of my personal bias around how I believe conscientious objection should be treated and prevented participants from agreeing with my statements and views. However, I could not remove my personal bias from the topics I covered in the interviews. By employing a semi-structured interview format and narrative style experience question I counteracted this somewhat, but I ultimately guided the interview topics with my subjective opinions. In addition, it is important to note that I received feedback from my supervisors on my research questions, interview guides, and pilot interviews. My supervisors' opinions differ from mine, meaning my own subjectivities did not go unchallenged.

Analysis

In the following section I outline the process of transcribing and analysing the data using 'found poetry' and feminist thematic analysis. I utilised NVivo 12 when undertaking the feminist thematic analysis.

Transcribing

I transcribed the interviews once I had undertaken them. I chose to transcribe all the interviews myself despite having funding that could have been used for transcription purposes. This is because transcribing is not a straightforward technical task (Bailey, 2008), it is an important step in getting to know the data as it is an interpretive process. It also requires decisions to be made as to what level of detail to document (Bailey, 2008).

Firstly, I imported the audio files into the Chrome Microsoft Word transcription tool. This tool noted the speaker and labelled each response with a time stamp. These time stamps proved useful when I was reading the transcripts alongside the audio. I then edited the transcripts, which revealed that some accents were picked up better than others. In the first round of editing, I focused on getting all the words written down that were spoken by the participant and myself. I then undertook a second round of editing once I had transcribed every interview to this level. In this round, I focused on the way things were said and noted: short pauses with a comma, longer ones with a full stop, and extremely long ones with ellipses, and I also noted laughter. I transcribed words that were emphasised in bold and represented stammers and elongated words with the addition of extra letters. Transcribing in this way seemed logical to me and built upon the knowledge I precured at transcribing workshops organised by the university. I did not follow specific transcription guidelines. Transcribing at this level was especially important in supporting my utilisation of found poetry. Thus, it was essential that I preserved the meaning and speech pattern of participants as much as possible, as the transcription process should complement the level of analysis (Widodo, 2014).

Omitting Data

One of the criteria for participating in the research was that participants spoke fluent English. This was not problematic during the first section of the interview as all the participants were able to articulate their experiences of abortion. However, some participants found the ethical and philosophical nature of conscientious objection difficult to navigate. This meant that I could not analyse elements of the interview transcripts. If I had analysed these sections, it would have reduced the credibility of the research. It is important to note that despite these issues, I still elicited fascinating, fruitful, and unique experiences of abortion. The limitations of questionnaires continued to outweigh their use.

Found Poetry (Poemish)

I utilised found poetry to present and analyse service users' individual experiences of accessing or trying to access abortion. Not only did the poetry contextualise the views voiced in the feminist thematic analysis, but it also served as data in its own right. Eisner (1997) commented that researchers must engage in "transforming the contents of our consciousness into a public form that others can understand" (pp. 4-5). They noted that poetry can "say what words can never say [as] [p]oetry transcends the limits of language and evokes what cannot be articulated" (pp. 5). Thus, poetry is a powerful tool in the analysis and presentation of qualitative data. Poetry re-creates lived experience (Richardson, 1994), changes how phenomena are understood (Eisner, 1997) and brings the reader closer to the work on an emotional level, while challenging the hegemonic role of prose in academic writing (Rogers-Shaw, 2021). Found poetry has successfully been used to analyse potentially sensitive and emotive topics (Rogers-Shaw, 2021; Sjollema et al., 2012; Wright, 2018), which abortion can be. It has also been incorporated into research methodology as a means of inquiry to inform policymakers, practitioners, and the public about the lived experiences of a variety of populations (Sjollema et al., 2012).

The participants' response to my first interview question: "Please describe your abortion journey in as little or as much detail as you would like" formed the text from which I created the found poetry. I constructed found poems for each individual participant. I read the transcripts numerous times, highlighting nuggets (Butler-Kisber, 2002), key phrases, and sentences that developed and demonstrated individuals' experiences (Hermsen, 2009, cited in Patrick, 2016), and were core to the journey undertaken by participants. Many of these nuggets were moving, powerful, meaningful, and thought provoking (Chilton & Leavy, 2014). I then transferred these nuggets onto another sheet of paper and arranged them to form a poem. I did not do this in a linear manner, as I referred back to the audio recordings and transcripts and revised the poems throughout to gain a sense of meaning, rhythm, and understanding (Butler-Kisber, 2002). This process is described as 'intuitively' sorting out words, phrases, sentences, passages that synthesize meaning from the prose (Glesne, 1997, cited in Prendergast, 2009, p. 547). This task of "removing material", is deemed a process of analysis which enables researchers to better understand and express participants' responses (Wiggins, 2011, p. 6).

In the same was as Patrick (2016), I have included a section of an interview transcript to illustrate how I created part of Charlie's found poem. I have highlighted the 'found' words from which I formed the poem:

"Erm so I, this is quite a long time ago, and I'm now 38. But when this all happened I was 20. So it was like 2003 and Ermm. I was very young, and I just left ** to go to University in **. I still live in ** now. Erm. I was attacked and and I wasn't that long away from home and. And, and it was all a bit of a scramble because there was like two things running parallel. There was like Rape Crisis support, and also, the abortion journey. And my first point of contact with my doctor, but I hadn't. Now when I look back, and think how should I could have done this better, but I didn't report it straight away. I did all the wrong things. I bathed. Got rid of evidence. I panicked because I knew my attacker. […]

And it really complicated things, and erm so. I first went to. I'd left it too late to do things like HIV prophylaxis. Although I did get tested and stuff. And, it was just a massive and big. It was a big scramble to get everything done, and I think a lot of erm stuff happened at once, so I think the process itself was traumatic, but not not necessarily because of the professionals involved with just. Because of the circumstances."

It is argued that found poetry allows those who are often silenced to be heard, as it acts as a tool for agency for those who are disadvantaged or oppressed (Sjollema et al., 2012). I reject this argument in view of my own programme of research, as ultimately it was my role as a researcher to 'find' the poetry by selecting the phrases and words to create the picture presented. Thus, although I used the words of each participant verbatim, they could not claim full ownership of the poetry. That being said, I worked closely with the audio recordings and transcripts to honour the participant's pauses, repetitions, rhythms, and alliterations (Wright, 2018). I represented participants' experiences holistically (McCulliss, 2013), and presented what may have otherwise gone unnoticed (Prendergast, 2009).

Furthermore, it is argued within the literature that those embarking on arts-based research should have a background in the arts (Piirto, 2002). However, Piirto contemplates whether poetry for the sake of qualitative research must be 'good poetry', as she comments that poems – regardless of quality – convey descriptive detail, give direct quotation, evoke emotion, and humanise participants. That being said, she concludes that for research to be truly arts-based, researchers should undertake training in the discipline in which they wish to work. This has subsequently been disputed and deemed an "uncomfortable fit" (Lahman et al., 2010, p. 47) in view of the argument that anyone can write good poetry. In fact, Emily Dickinson, one of the most influential figures in American poetry would not fit the criteria implemented by Piirto (Lahman et al., 2010). Despite this, I attended a short poetry course through the Open University and read poetry, as Lahman et al. (2010) suggest, to become somewhat enlightened and to understand poetic method. However, it is important to note that the poetry I present in this programme of research is "poemish" (Lahman et al., 2019). It was not my intention to create poetry in line with poetic method; whilst I borrowed from this, and was informed by the training and reading I undertook, my core aims were to express the data while staying true to the experiences of participants (Patrick, 2016).

Reflexive Feminist Thematic Analysis.

I conducted a reflexive feminist thematic analysis by employing thematic analysis (Braun & Clarke, 2013; Clarke & Braun, 2021) through a liberal feminist lens; I focused upon power, law, and policy. I outline the process I undertook in Figure 3. I have presented it in this way to highlight that it was not a linear process.

Figure 3: Conducting a reflexive liberal feminist thematic analysis

I familiarised myself with the data and the liberal feminist approach. I read through all the transcripts while listening to the audio recordings. I made notes as a form of active listening to gain insight into participants' views on conscientious objection. I read through the liberal feminist framework. These initial notes were not codes but marked ideas for codes.

Stage one of coding: I generated initial codes. I worked systematically through the data set paying equal attention to all elements. I coded phrases, single words, or sections of the text using NVivo 12. I coded opinions before and after I introduced Wicclair's (2011) three approaches, and opinions on: institutional conscientious objection, Doogan and Wood, abortion, regulating conscientious objection, the structure of the healthcare services, healthcare professionals' roles within their occupation, organising conscientious objection, the impact of conscientious objection, religion, and the impact of abortion and personal identity on opinions. These initial codes allowed me to understand participants as individuals, and the evolution of ideas throughout the interview process. I referred back to these codes when I created the themes (stage five), and in the final write up.

Stage two of coding: I generated descriptive and latent codes in a separate NVivo file. I worked systematically through the data set giving equal attention to all elements, I coded phrases, single words or sections of the text using NVivo 12. Codes were data driven rather than theory driven. I coded for all potential themes and patterns, and kept data that surrounded codes – this provided context. Descriptive codes focused on what the participants were saying (Jenkinson et al., 2017) at a semantic level.

I then created themes. This involved collating codes into potential themes. I gathered all the data relevant to the themes, I created both sub-themes and main themes. I did not abandon miscellaneous themes.

I defined, named, and further refined the themes. I identified the essence of what each theme was about and determined what aspect of the data each theme represented. I returned to the collated data extracts for each theme and organised them into a coherent and internally consistent account with an accompanying narrative. I considered the narrative from each theme as one overarching narrative. I ensured this made sense, flowed, and that there was not too much overlap between themes. I gave the themes names which I used in the final analysis. I did not try to get themes to do too much or be too diverse and complex.

I reviewed the themes and read all the collated extracts for each theme, ensuring they formed a coherent pattern. I considered whether the theme was problematic, or whether data extracts were in the wrong theme. I reworked these accordingly by either creating a new theme, working them into a current theme, or removing them from the analysis. I created a thematic map to visualise the data. I assessed the validity of the themes, and the thematic map in relation to the data set, by re-reading the entire data set. This was not a linear process as I had to re-code from the data set, as coding is an ongoing organic process. Once I was happy with the thematic map, I moved on to the next stage.

I analysed the themes on a latent level from a liberal feminist perspective. I identified underlying ideas, assumptions, conceptualisations, and ideologies that shaped or informed the semantic content of data. I used the thematic map to develop these analyses and discussed the findings with my supervisors. Not all the latent codes I created were inherently feminist, though the majority were guided by this.

I produced my programme of research. I provided a logical, non-repetitive, and interesting account of the narrative told across all the themes, combined with the latent analysis. I contextualised this in relation to the existing literature.

Reflective stop-off:

After I had undertaken the reflexive liberal feminist thematic analysis, my supervisory team and I discussed whether my programme of research is liberal feminist or radical feminist, as participants sometimes voiced opinions that supported the radical feminist perspective on conscientious objection. We concluded that my programme of research is liberal feminist, as it sought to uncover power imbalances and identify experiences and views to alter current policy and guidelines rather than challenge the current legal system and hierarchy. However, I did not omit views that did not fit within a liberal feminist framework. Thus, I also uncovered radical feminist perspectives in my analysis.

Quality

In the following section I assess the quality of my programme of research by demonstrating how it meets Lincoln and Guba's (1985) criteria. These criteria are commonly accepted within qualitative research and are used to assess credibility, dependability, confirmability, transferability, and the late addition of authenticity (Nowell et al., 2017). There are arguments presented against the creation of universal qualitative criteria due to the diversity of qualitative research and differing opinions over how it is best to assess it (Finlay, 2006). I acknowledge these arguments and agree with them to some extent, as quality criteria are ultimately socially constructed lists of characteristics rather than abstract standards (Kvale, 1995). However, I believe that Lincoln and Guba's (1985) criteria are useful in assessing the trustworthiness of my programme of research.

Trustworthiness

Credibility

The credibility of a study is deemed the most important criterion (Polit & Beck, 2014). Its concern is whether the researcher has demonstrated a good fit between “constructed realities of respondents and the reconstructions attributed to them” (Lincoln and Guba, 1989, p. 237). Credibility is analogous to the measure of internal validity in quantitative research.

To increase the credibility of the research, I discussed what conscientious objection is with each participant at the beginning of each interview. Firstly, I asked the participant if conscientious objection was a phrase they had heard before, re-assuring them that it was not a test. Regardless of the response, I gave all participants the same definition of conscientious objection: "It is the refusal to participate in an activity that an individual considers incompatible with their religious, moral, philosophical, personal, or ethical beliefs." I then followed up with a simplified explanation to ensure all participants understood the term: "So basically, it's when a healthcare practitioner like a doctor, nurse or midwife decides that they don't want to or cannot participate in an abortion, for personal reasons, or reasons such as religion, or anything that will have an impact on their conscience."

I then checked with participants that they understood this, leaving room for further questions. This ensured that all participants had a basic understanding of conscientious objection. This increased the credibility of the liberal feminist reflexive thematic analysis, as participants understood the topic being discussed. Moreover, I excluded data that presented an obvious misunderstanding. It is important to note that fewer misunderstandings were evident when participants recalled their abortion journeys.

Moreover, I presented participants' realities and experiences using found poetry. I decided to implement this type of analysis over case studies and non-verbatim poetry. Found poetry allowed me to accurately represent the version of reality participants created with me during the interview process. I worked closely with the audio recordings and transcripts to honour the participant's pauses, repetitions, rhythms, and alliterations to represent participants' experiences holistically(McCulliss, 2013). Thus, found poems represent a credible form of analysis.

I did not employ coding reliability procedures as these capture a neopositivist approach which posits that 'objective' and 'unbiased' coding can be conducted (Braun & Clarke, 2021). Instead, my supervisors and co-workers acted as a 'fresh set of eyes' to ensure that codes, themes, and my interpretations made sense in relation to the data. This supported the philosophy that coding is subjective and cannot be replicated by others. I decided not to member check and did not give participants the opportunity to review their transcripts or found poems. Member checking would have increased the credibility, however as abortion has the potential to be a sensitive topic it could have caused unnecessary distress. Moreover, to increase the credibility of the research, I presented my progressive subjective understanding of the topic and the research process in a reflexive journal (I outline this in the section titled 'subjectivity').

Dependability

Dependability refers to demonstrating how methodological changes and shifts in constructions have been outlined and presented (Lincoln & Guba, 1985). I noted all research decisions and methodological changes in a reflexive journal and in the minutes of supervisory meetings. I clearly outline these decisions in the methodology. For example, I presented a clear case for choosing interviews over quantitative methods, despite being enticed by the prospect of undertaking a more representative study on conscientious objection. I also explain why I chose not to undertake case studies in the section titled 'the case for not using case studies' after I discovered that found poetry could be employed to present all the participants' experiences.

Confirmability

According to Lincoln and Guba (1989, p. 243), a "confirmability audit seeks to clarify where data came from (e.g., interview, document, observation) and how such data were transformed into the presented findings." I provided a detailed account of where data came from, as I described how 25 semi-structured interviews were undertaken. I gave a breakdown of participants' demographic information and the interview modes utilised. I have attached the interview guide in Appendix A and made interview transcripts available on request. I also presented the methods of analysis in the section titled 'presenting and analysing the data'. The outcome of the programme of research can be clearly mapped from my data collection and analysis processes. Thus, the findings are not simply "figments of [my] imagination" (Lincoln and Guba, 1989, p. 243).

Transferability

Within the quantitative paradigm, there is an expectation that research findings are generalisable. However, as my research was qualitative, I did not aim to produce generalisable findings. Instead, I intended to provide thick descriptions. I achieved this by utilising found poetry and presenting participants' demographic details. This means the reader can transfer the findings to their own research site to judge transferability (Nowell et al., 2017).

Authenticity

Authenticity concerns the extent to which participants' lives are realistically conveyed, whether a range of different realities have been depicted both fairly and completely, and if the research will improve the research situation (Polit and Beck, 2014, cited in Connelly, 2016). Although participants responded to my recruitment material (voluntary response sampling), I attempted to recruit from a variety of groups and communities. I posted recruitment material on a range of internet pages, including transgender/non-binary Reddit, religious forums, and mumsnet.com. I did not refuse any participants who met the inclusion criteria. Thus, my sampling methods were fair, and I did not omit participants to influence the findings.

I realistically conveyed participants' realities, as I utilised found poetry to present each individual's abortion journey verbatim. I also presented verbatim quotes within the reflexive liberal feminist thematic analysis to highlight how I drew the themes from the data. I practised negative case analysis, as I included all the transcripts in the analysis unless participants misunderstood the subject. I paid equal attention to all of the transcripts, however some participants feature more than others in the liberal feminist reflexive thematic analysis, simply because we had more in-depth discussions, or discussions that lead to topics that I had not foreseen. I did not omit data if they did not fit my preconceptions. Had I not employed this procedure, I would have removed the transcripts of service users who labelled themselves anti-abortion, as these views did not fit my initial expectations. Instead, I included these cases to present a more authentic, balanced, and inclusive explanation.

Moreover, my programme of research could be labelled as inherently ‘giving voice’ to participants. However, I reject this concept as it assumes a fixed power dynamic between the participant and the researcher where the researcher can empower inherently disempowered participants. Nevertheless, I argue that my programme of research provided a platform for participants to voice their views within academia, which in turn has the potential to improve the research situation by challenging and reimaging the philosophical and theoretical arguments which currently dominate the academic literature on conscientious objection and inform healthcare policy and guidelines both nationally and internationally.

Conclusion

In this chapter I have discussed the methodology underpinning my programme of research. Firstly, I outlined the ontological, epistemological, and theoretical approaches I adopted. I then discussed participant recruitment, and my choice of research mode. I explored the rationale underpinning my decision to undertake semi-structured interviews whilst incorporating a narrative approach when discussing lived experience. I explored how feminist methodology informed the way in which I conduced the interviews. I also discussed the sociocultural nature of abortion in the UK and the implications this had regarding ethics, as well as the potential ethical issues that arise from such research. Following this, I discussed how I analysed the research. Finally, I discussed transparency concerning the trustworthiness of my programme of research using Lincoln and Guba's (1985) framework.

In the following chapter, I present the findings relating to participants' experiences using found poetry.

Chapter Four: Analysis of Participants' Experiences Using Found Poetry

I used found poetry to analyse participants' experiences. I present these poems in the following sections: participants who experienced conscientious objection, participants who experienced non-smooth access or treatment for reasons that may or may not have been conscience based, participants who did not experienced conscientious objection.. I provided a platform for service users to share their experiences of abortion and conscientious objection and used a holistic method (McCulliss, 2013), of analysis to reflect the liberal feminist underpinnings of the research.

Participants Who Experienced Conscientious Objection

Charlie

I was very young,
twenty. I was attacked.
I did all the wrong
things. I bathed,
got rid of evidence. I panicked
because I knew my attacker.
It was a big scramble
to get everything done.

The process
itself was traumatic.
Not because of the professionals
involved, because of the circumstances.

The first GP

I went to. She did tell me that
she didn’t agree
with it, because of her background,
her beliefs.

It was handled
in a very sensitive way. I didn’t
feel judged.
I respected her decision
and she respected mine. The right
amount of balance.

She said I’d need to speak
to another GP.
I wouldn’t have to wait long
for the second referral, to go to a different doctor.
Within a week it was resolved.

Then I was referred
to The Brook service
I had the medical
procedure. I was eight weeks
so I just took the tablets.
I had support from Hayden,
and support from The Brook centre.

That was my journey.

Emma

I was eighteen. I had two

different tests. Saying two different
things.
We have a family doctor, she knows my mum.
I went there to confirm.
I was really scared
she was gonna say something

It was positive.
Right there and then
I just said
I didn’t want to keep it.
She said my mum
needs to know.
She needs
to have her say.
That it wasn’t the only option.

I knew what I needed
to do, I didn’t want anyone
else influencing my decision.

I asked “where
do I go from now?” “Can you
refer me?” “Give me a different
Dr?” She said
“No everyone’s busy
just look online”.
She didn’t really even give me any information
or websites

It was very

discouraging. I was thinking
am I making the right decision?
She went about it
the wrong way.
I'm not sure if hers wasn't relevant for religious views.

I was really clueless. Do I
go to the GP? Do I call?
Do I have
to pay?
She didn't give me
any further information.

I had to call
and specifically
ask for someone else. I made an appointment
two weeks later.
She was helpful. Let me know
my options.
What would happen
if I do. What would happen if I don't.
She was able to refer me.

I had the pills.
It was quite
early on. Easier just to
pop a pill and be done.

Jess

I was around 25. I was experiencing

homelessness and other issues.
I had a long term
boyfriend at the time. I found out
I was pregnant. He wasn’t
happy. It was more along the lines of threats.
I could have been killed.
He wasn’t joking.

I decided I had
to do it. If I can’t
look after myself, I can’t
look after a child.

I went to make an appointment
with the doctor. The appointment came
around, I didn’t sleep
the night before.

I said “I’m pregnant
and I’d like to have an abortion”.
“I can’t do that for you.”
That was it.
I’m just assuming religious reasons.
But I could be wrong

I started crying.
I was already feeling
really distressed. I just wanted
to get out of there.
It was absolutely horrific.

Thinking about it just makes
me angry.
You have the means
to help me. And you don’t
want to.
After that it was this awkward
silence. He was giving
me this half-assed sympathetic look.
He just didn’t do anything.

I just said “ok
thank you”, and walked
out, up to the reception in tears.
She had to rebook.
I had to wait again. I walked out
in absolute disbelief.

Eventually everything
did go ahead. It was surgical.
They were nice. They were
friendly. They weren’t judgemental.
I think it was a Marie Curie clinic.

It’s not an easy
choice to make. If it had been different
circumstances, I wouldn’t
have chosen an abortion.
I just felt like my hands
were tied.

Katie

I wanted to do
the abortion. I was not comfortable
to keep the kid.
It’s not like I was stable
financially. I was also doing studies.

He was the main
Dr in the hospital.
He refused
to participate. It was his personal
beliefs. He felt it was like killing.
He said he’s a religious man.
His faith
could not allow him.

I tried convincing him, giving
him more money.
He refused completely.
I felt bad.
He tried convincing me
of not doing it. Maybe
I might not be able to have a kid
later on in life.
Maybe there was an effect
on the womb. Maybe I’d be feeling
like I killed someone.

I had second thoughts
at some point. The need

of wanting
to get rid
of the kid was much more than this feeling.

I had no idea
where to consult.
I didn’t want to have the later consequences
of having the abortion in the wrong way,
the wrong place.
I wanted him
to help me
even if he couldn’t himself.

He referred me. He had no
other choice. I went to BPAS
after two days.
After consulting
I did the abortion there.
I was two months. In the end
I was just given some pills.

Maria

My experience
was in the summer of 2018.
It was from a pregnancy
with a long term partner.
I found out in Italy
my home country. I decided to go back
to England
because of religious conflict

conscientious objection is a lot more common there.

So I returned
to the UK. Immediately I researched
the options.
I pretty quickly decided
I wanted to end the pregnancy. I was around
fourteen weeks.

I didn’t have a very positive
experience with my GP. They weren’t
on board. My answers were
very much contested.
Devil’s advocate.
I was aware they were strongly religious.
I was not referred.

I was scared
that’s going to be the reaction everywhere.
I was upset
having to answer all those very personal
questions. It was quite
frustrating.

I then contacted another reproductive clinic.
I found them to be a lot more supportive,
less judgemental.
I ended up going through with them.
It was surgical.

Participants Who Experienced Non-Smooth Access or Treatment for Reasons that May or May not Have Been Conscience Based.

Harshil

This happened during lockdown.
We were planning
to abort
because of personal reasons.
It was late
already into the twenty second
or twenty third week.
We were not really aware
of the ideal time
for aborting.

We spoke
to the GP.
Everything was pretty much fine
and normal.
The GP wasn't really convinced
with the reasons.
That was the first hurdle
we came across.

We tried consulting
private clinics.
Even they were not
taking this forward
because it was twenty plus weeks.
They felt it could be harmful.

We decided to go ahead
in my partners
home country, India.
We were given assessments
again. Even they
were trying to console us not
to abort the baby
because of hospital policy.

We decided to go ahead.
It happened within days.

Rosanna

We found out
at the start of February
last year. Something wasn't right.
I was putting off
doing the test. I thought
it can't be that. Unfortunately
it was. I was devastated.

We originally went to BPAS
They were really helpful.
Other than the lady who did the sonogram. She
told me to lie down, was really stern.
I was getting visibly
upset. I just wanted her to stop.
I kind of just persevered.

I was over
ten weeks so they had to refer
me to my local hospital.
I had to wait two weeks,
which was quite traumatising. I just
wanted to get it over with.

It was a nurse,
and a trainee nurse. She was
pressing the machine into my stomach.
I was having really bad pain.
I was getting a bit
stressed. The trainee nurse frowned.
Not really
what I want to see. I was in tears.

They wanted to examine
inside, “I won’t
perform that on you.” She said
“I can, but I won’t.” It was just very
confusing. Very unclear.
The nurses went behind the curtain,
and started whispering.

They both just disappeared.
I felt extremely uncomfortable,
very upset. Vulnerable
and afraid.

Then another Dr
thankfully came along. My

uterus was tilted.

I went for a full
operation. Under aesthetic.
I believe
it was the surgical one.

Keeva

In 2019 I got
pregnant. I was eight
weeks. The only option
I had was to terminate.
I went to a clinic
to search for the services. A Dr
in a public hospital.

I was denied, because of the reasons
I gave. Maybe he thought
I was stressed. Which today
I agree with.

They agreed to terminate
because of medical condition.
Maybe the mother cannot
carry the pregnancy.
Or maybe the child
won't survive. They were very rigid.

My Dr told me, just go
and decide. I was given one month

to think. He referred
me to a councillor.
I talked to my friends, those
who have been in my shoes.
They advised me
to keep it.

I changed my mind
and I delivered
that baby. Now I come to think
that the Dr
was right. If I had an abortion maybe
I would have regretted my decision?

Janie

I went to university
hospital. I didn't tell them over the phone.
I would be able to explain
myself better if I could go to the hospital.
They referred me to another hospital,
because they don't do it there.
It took around two weeks.

I was around five weeks.
I wanted to go back
to school. It wasn't a good enough reason
as to why I was seeking the abortion.
It was so
hectic for me, with the burden.

They give me another
appointment. They weren’t so strict
with me. The second time
I told them it was health reasons.
It was not easy,
because time was running out.

They had to do their own test.
When they called
me they gave me some tablets.
It took me around one month
to get the medication.

Holly

Got the pill at 18.
I was profusely vomiting
it didn’t work.
I was pregnant, to a disabled person,
I presumed.

I went to my GP,
he was a family GP.
He referred me to the pregnancy advisory service.
I was embarrassed.

I done it for professional reasons,
for medical reasons.
There was no way I could have coped with a child
at that stage.

It was a 12
week vacuum aspiration,
they actually suck.

As I was going under
I heard, “and this one, this one’s a midwife.”
It really affected me.

I knew what a foetus looked like.
I asked to see it.
It was nothing,
it was just a mass of blood clots.
But I wanted to see it.

I said a little prayer,
blessed it’s kinda soul a little bit in my heart.

Amy

I was 19 years old. I had never heard
about abortion, up until that time.
I never knew what it really entailed.
I just knew it would solve the problem.

I struggled, in my conscience.
If it was gonna be the right thing for me to do.

I had a scan
I was able to see my baby.
Connected to my child.

I struggled so much
I left the country.
I was trying to rationalise things in my own head,
come to my own decision

I had this habit of spitting. I couldn’t tolerate
my own spit.
I couldn’t bring myself to actually telling my family.
My mum was in the dining area she said
to me “you’re not going to bring an illegitimate child
into this house.”
How does she know?

I walked past her, sheepishly
went up to my room.
I’m just gonna have this abortion,
just put it behind me.

I used to sort of talk to my baby
hold on to…
what I knew wasn’t going to be there

I was almost twenty
weeks. They gave me some pills,
I remember feeling a harddd, rock like feeling
in the lower part of my abdomen

Then I was taken
to theatre
put to sleep.

I came round,
pain,
I just felt so empty.

I remember saying
to the lady “where’s my child?”
She turned around and
said to me “You silly girl,
don’t you know what you have done.”
I was just sent home.

I was having nightmares,
cold sweats, tremors.
I would tuck myself right
underneath the sink
in the middle of the night.
I’d just cry,
I just could not forgive myself
for what I had done.

Nadia

I got told that I’d struggle
to have kids. I was on the pill
for period pains. It’s my own fault
for not using condoms.

I was seventeen, I was really
ill. My mum ended up taking
me to the hospital on Christmas Eve.
Found out I was pregnant. Obviously,

a massive shock.

My mum was dead supportive
“I’ll be there
whatever you need, whatever you
wanna do.”

It wasn’t the right time
for me to have a baby.
I spoke to the Drs. They referred
me to the women’s hospital.

The woman that done the scan
knew I was having an abortion. She was
still showing me everything. I really struggled
with it.

I went to BPAS. I was roughly
nine or ten weeks. I’d have to go for a surgical
termination. They put me to sleep.
I had a reaction.

This is how I’m going to die.

Obviously I woke up.
I woke up crying. I didn’t understand
why.
I was talking to another person there, her baby
had died. She had to get it removed.
I felt really guilty. I have chose to do this.

For about two years
I really beat myself up about it. I struggle
because I lost a baby in 2016.
But it was the right decision
for me at the time.

Diana

I was sixteen, fell
pregnant. I was railroaded
into an abortion. I didn’t
want one at all. In 1984
when your parents told you
you were going to do something, you
did it.
It was either that, or be put out.
It was very difficult
to come to terms with.
Before, during, and after.

It was a GP appointment
first. Then we got referred
to the hospital. I would imagine
it would be vacuum. I’m not
one hundred percent
certain. I was under anaesthetic.

I can’t tell you about going to book
the abortion,
about the day of the abortion. I can remember
coming home after it.

That was quite
traumatic.

I can recall going for a check up
four to six weeks after. I cried
a lot a lot a lot
in those weeks. It was a young
Dr. The way he treated me was very rough.
I just knew he disagreed with abortion.
There was judgment there.
It’s something that stayed with me as long as the after effects
of the abortion

Participants Who Did not Experience Conscientious Objection.

Jennifer

The nurse that I met,
I found online,
said I could undertake the abortion.
She told me to go to the hospital
around lunchtime. So we could talk.
At lunchtime other staff are not
there. So I went
and explained my problem.

She told me that I
have to come
with my husband. That was very tricky,
the pregnancy
was not associated with my

boyfriend.

I tried to explain
to the person who made me pregnant,
take me there,
to the hospital. He refused
because he was married.

After some time
I went back to the nurse
and explained
my problems. Again she refused
and told me that I have to come with my
mum. Regulations.

It was a secret.
I never
wanted any disappointment.
It never worked.
I never accessed abortion
in the clinic.

I was almost four months.
I had to go and buy
the abortion pill
from a pharmacy.

I did this for myself
alone.
When you do it yourself
it is painful.

All alone.
Nobody knows.

I swallowed
one pill.
After twenty four hours I put
them in my mouth
and never
swallowed.
After twelve hours
I started feeling bad.

I never regret
taking that decision.
It worked well for me.
That's my story.

Kathy

I was 16, in a relationship
with a guy.
I went to America, on holiday.
I missed a period
again,
for the second or third time.

There was no conversation
when I got back,
unanimous kinda solution to our problem,
just go and have an abortion.

I booked my first ever
Dr’s appointment without my mum.
There was no discussion.
The pregnancy test was given to me.
“I don’t think my parents will be happy.” I said.
“fine”, signed the paper.

Letter through from Marie Stopes,
opened that in the privacy of my room.
I didn’t want anyone to find out.
Had my date set for a month
later.

It was a surgical abortion.
Under anaesthetic,
everyone was smiling.
There was a long room,
with lots of beds
and other girls in there.

They did a scan,
turned the screen away.
I couldn’t see.
Was given the anaesthetic.

The next thing I remember is waking up.
It was daylight, they offered
me some toast.
I must have passed out, again.
The next time I woke up it was dark outside.

No one was smiling after that.

It was awful.
The pain was just...
something I can’t put into words.
I couldn’t stand up,
just a nightmare.
Trying to conceal it
when I got home.
I never ever heard from Marie Stopes again.

Tia

I was sixteen, I had just met
my fiancé. I didn’t really think I was pregnant.
I just had this funny feeling.
I went to a sexual health clinic.
They did the test. Within five minutes I had agreed
the route I was going to take. It was really quick, no
“are you sure?” I didn’t
want to ruin my A-levels. Or my chances
of going to university.

It was booked
for the following week. I was only
six weeks along.
It was just the medical tablets.
Orally first, then into the vagina.

I didn’t tell my family at first. I tried to hide
it. When it came

to the day, I had to tell them.
It's just something you can't really hide.

Jane

I've had two.
My first was when I was eighteen.
I didn't know
I was pregnant. I went to the GP.
They took my urine
sample. You have to wait two
days. It was positive.
They didn't arrange anything,
that was it. Sort of left.

My mum took me to Marie Stopes.
That abortion was quite traumatic
because it was about fourteen
weeks.

When I was twenty eight
I got pregnant again. I just
bought a kit from the chemist. Found out
at seven weeks.

That was a harder
decision to make. I had a job.
But I didn't have a partner
I could rely on. My life
wasn't secure.
I just accessed [an] advisory

centre, went straight there.
I never felt judged.

Pam

I don’t have any kids.
I’m really on the fence
about it. It’s just such a major thing.
I’m very divided.

Overall I’ve had
three. Which I’m not -obviously- proud
of at all.
The first two were a long time ago,
in my late teens. The third
was still some time ago.

I find it really embarrassing.
It’s not very
responsible. But it’s just pure circumstances.
It wasn’t right
at the time. None of the three occasions.
I was too young.

Straight to the Dr
every time. Before my first
I had suspicions, they conducted the final test
to confirm. Second time, I can’t remember
if I already knew for definite.
The third
just to confirm what I already knew.

Generally the routine was the same.
I discussed the options
and what I wanted to do. They encouraged
me not to rush into anything quickly.
Think it through
wisely,
carefully.

Operation
every time.
I couldn’t do the pill,
I’m to squeamish.

The first was the longest,
ten weeks. The second
roughly the same. I think the third
was more like eight.

They were very fair. I felt it was morally
right for both parties.
I don’t see it as a massive loss.
Because if I want to I probably
still can.
I’m over it now.
Time is a great healer
as they say.

Bao

I had it last year. I think
it was the four pill thing.
I was two months
pregnant at the time.

It was inside of Boots.
I found it online. One week
between the phone call
and the abortion.
It was an easy process.
They just went for it.

Sarah

My first one
was when I was eighteen.
I was forced
into it by my family.
Doctors never really got into why.
It was just very
very rushed. Next thing I know
I'm in
and it's all being done.

I was under general anaesthetic.
You get put on an antenatal
ward after. Which was the most upsetting
thing. There's people with their babies.
You feel a bit disgusting.

The second experience
was quite similar.
I found myself pregnant
by someone other than my partner.
That was obviously
to save the relationship.

Again with GP, straight up
to the local hospital. The second one
was with the pessary.
And then you take another tablet
I think.

I passed it all. At home
on my own.
I could see the baby, the whole
thing.
It was quite traumatic.

I was very unhappy about it,
very sad.
It had to be like that at the time.
If I had talked about it
a little bit more maybe I would have made
a different decision.

Elise

My periods are like clockwork
every month. I did a test.

My line came up really quickly.
It was the worst time possible. I was
doing my masters.

I went through Marie Stopes.
I think I was seven weeks.
They did the scan. Told me
“these are your options”. “I’m not
taking the pill version. The pill
is gonna make me feel like
I’ve had a miscarriage.”

I booked in the following
week. They put me to sleep.
I actually remember
them talking to me, saying to count.
That was the last thing
I remember. I was gone.
I remember coming around.
My partner and sister came.

I just thought
ok it’s done, I’m fine.
I was tired for a few weeks,
feeling weak. It was the right
decision. It was what it had to be.

Dani

I was pregnant
from a guy I was seeing.

He was just like “whatever
you
do I’ll support you.”
He was really nice.

My family are anti-abortion,
pro-life. I would never tell them.
I knew what I wanted to do.

I know there was nothing
in me that would ever want to have a baby.
I’m not mentally or physically prepared.
I’m still at uni.
It’s the worst thing
that could happen to me.

I live with my best mate.
I told her.
Straightaway on the phone, typed
in abortion services.
Talked to this woman,
It was as easy as that.

Three days time
I get the procedure done.
My best friend
waited outside. Because of Covid
they wouldn’t let me have anyone
with us.
It was a bit shitty.
Everyone in the clinic was so nice.

I felt
at ease. The first woman
did a scan. She was lovely.
She never said “what would
your family think? Are you sure
you wanna do this?”

A new woman
took me in. She gave us the first
tablet, and then sent us home
with the next one.
That was it. It was so quick.

Aisha

I just fell in love
with someone. In Islam
you have to sign
something to say that you are married,
then you can have sex.
But it kind of just happened.

My parents found it embarrassing,
disrespectful.
They wanted me to have an abortion.
It was difficult. It was an awful
experience.

I went to my GP
It was kinda like “It’s your choice.”
It was a very

difficult choice. A very
very difficult decision.

I went to the hospital.
They were very supportive, friendly
enough.
It was surgical.
I was trying to be in the moment,
but it’s very difficult.

Ashley

It was clear from the start
I was going to have one.
It was never
a question.
I wasn’t sure
what you do? Where you go?
Who you chat to?
I concluded on going to a
sexual health clinic.

There was a lot
of people involved. A couple
of nurses, a GP.
They referred me.

There was one key
appointment. He run me through
the psychology
of it, after effects. Making sure

this is the right thing to do.
Making sure you’re ok.

My procedure
was one where you go to sleep.
They put you under, in the hospital.
I guess it was kind of quite simple.
It’s not something I regret.

Lauren

I was 19, in a relationship.
We’d been together for about three years.
I never saw myself staying with this person
forever.

I became pregnant
by accident. I was really shocked.
He felt that it was my
decision. He wasn’t going to try
and sway me either way. I certainly
felt supported by him.

Making the decision
itself was relatively easy. There was no
part of me that had any doubts.
There was a number of different
factors,
the likelihood of the relationship lasting, the suitability
of my partner, my own experiences
growing up, whether I did want to have children

at that stage.
Everything pointed me in one direction.

I didn't really know
how to proceed. I went to a local family planning clinic
to get my options,
without committing.
I wouldn't say there was much warmth, in the room.
maybe that's exactly how it should be.

I decided to wait. Just a little bit,
I was only 8 weeks
I knew that I had time,
I wasn't under pressure to make a decision
quickly.

I went to see a doctor. I found going to the Dr
probably a bit harder
because I'd made a decision. I knew
what I wanted to do.

Hospital. It was always very
professional.
It was a medical pill.
Focused, on getting through it

Reflective stop-off:

I encountered some issues around how I should present the found poetry, as my supervisors commented that listing the poems one after the other could make them less impactful as the reader's eyes may 'glaze over'. It would not have been possible for me to disperse the discussion throughout the poetry as several sections of the discussion are relevant to all the poems. If I had presented the chapter in this way, it could have made it difficult to follow and disjointed. Another option my supervisory team and I discussed was removing some of the poems from the final section ‘participants who did not experience conscientious objection. I argued this would go against the feminist principles of the research as: (i) participants would have given their time and I would not be representing their abortion journeys, and (ii) I would have to decide whose abortion journeys were more worthy of representation, when each participant offers a unique personal experience. In other words, one journey is no more valuable than another when trying to establish how service users experience abortion. For these reasons, I decided to present all the found poems and then the discussion.

Discussion

In the following discussion I do not focus upon participants’ reasons for accessing abortion or the age at which they accessed abortion. Participants viewed these details as important when describing their abortion and they add context to illuminate their circumstances. However, it is argued that focusing on the reasons why service users abort stigmatises abortion further, and perpetuates a binary of deserving and undeserving service users (Love, 2017). Instead, I focus on how participants accessed abortion, and the involvement and impact of healthcare professionals, as these factors have important ramifications regarding conscientious objection and for answering the research questions: 1. What are the abortion journey experiences of service users in the UK? 2. Have conscience clauses in abortion legislation affected UK service users’ reproductive rights regarding access to and experience of abortion? In what ways? I used liberal feminism to inform this discussion as I discuss the poems considering unequal gender power dynamics, power within the health service, and liberal legal change.

Accessing Abortion Services

It can be argued that the conscientious objection clause is often bypassed in the Britain as 77% of abortions in England and Wales in 2021 were performed by NHS-funded private clinics, such as BPAS and MSI (Department of Health and Social Care, 2023). This could indicate that service users are self-referring when accessing abortion and are not approaching GPs. If service users are self-referring it is unlikely that they will encounter an objector, as it would be unusual for a health care professional working at an NHS-funded private clinic to conscientiously object. However, this statistic doesn't consider those service users who have been referred to these services by their GP, or those who have sought out these services themselves after a lack of referral from their GP or another healthcare facility. Elise accessed her abortion directly through MSI, while Rosanna and Dani approached BPAS to access an abortion. However, most participants chose (or were only aware of) alternative access routes. This finding was supported by the latter part of the interviews as I focused on service users' views, as participants commented that they would not have known how to access an abortion without their GP. Previous findings show that service users in Britain have reported that they are reliant on their GP due to lack of knowledge of abortion services (Harden & Ogden, 1999; Lie et al., 2008), and those who have accessed abortion via self-referral commented that more information is needed for the general public on how to access abortion this way (Low et al., 2020).

Furthermore, one's GP was viewed as an appropriate access route to abortion, as most participants accessed their abortion this way. This could reflect the historical role of the GP as the 'first port of call' for individuals seeking a pregnancy test before home testing was introduced (Olszynko-Gryn, 2019). Pam and Sarah chose to procure abortion through their GP on more than one occasion. Participants who initially visited their GP saw this as the most logical route, commenting without question and as a matter of fact that the first healthcare professional they approached was their GP. This reflected the findings of Finnie et al. (2006), as they discovered that 82% of the 132 participants in their London-based study were referred to an abortion advisory service by a GP. However, it is important to note that Finnie et al.'s (2006) findings are outdated and focused on an urban area.

Moreover, not all participants were aware of the access routes to abortion. This is despite claims within the literature that there is a plethora of advice for service users online, meaning access should be simple and safe, as noted – but not supported from a conscience absolutist approach – by Cowley (2017). For instance, Ashley stated, "I wasn't sure what you do? Where you go? Who you chat to?" This resulted in Ashley attending a sexual health clinic and she accessed her abortion in hospital. Similarly, Lauren "didn't really know how to proceed" so she attended a family planning clinic and then visited her GP once she had decided to abort. The inference here is that she felt visiting the GP was the most appropriate way of accessing abortion after receiving information about her options from the family planning clinic. By contrast, Tia attended a sexual health clinic, seemingly without questioning her access options.

Participants also attempted to access abortion via non-conventional access routes due to a lack of awareness and potentially because of language barriers. For instance, Katie attempted to access abortion through a public hospital; she believed she had to pay for an abortion and commented that she did not have the knowledge to access safe abortion without a referral. Conversely, Jennifer took an unconventional route and met with a nurse – whom she had contacted online – in a hospital cafeteria while the nurse was on her lunch break. Jennifer was unable to access abortion through the hospital, as she could not confide in her friends or family, which meant no one could accompany her as per hospital policy. Instead, she had a medical abortion alone. She explained that she purchased the pills from the pharmacy in London, which is not legal in the UK (without a prescription), nor is it routine to access a medical abortion when four months pregnant. This perhaps implies illegal actions on the healthcare professional's part, or perhaps Jennifer did not want to disclose that she accessed abortion through illegal means. This highlights why the Abortion Act was passed, to prevent illegal abortions leading to death or severe mortalities. Keeva also attempted to access abortion in a public hospital, though the law in NI at the time (2019) prevented her from legally accessing abortion and she was referred for counselling.

Moreover, not all participants were aware of self-referral routes to abortion, indicating an unequal power dynamic between healthcare professionals and service users, as the latter relied on healthcare professionals to access vital care and struggled without their guidance (Shahvisi, 2018), contrary to the stance explained by Cowley (2017). This was especially apparent for those whose primary language was not English. Thus, it seemed one's grasp of the English language impacted the route they chose, or thought they were able to take, to access abortion. In several cases, GPs were relied upon and seen as an appropriate means of accessing abortion, suggesting the conscience clause may not be being bypassed to the extent the statistics – on numbers of abortions procured via NHS-funded private clinics (Department of Health and Social Care, 2023) – imply.

Healthcare Professionals and the Decision-Making Process

It is argued that most service users who approach healthcare professionals have already decided that they want to access an abortion (Baron, Cameron & Johnstone, 2015). Whether healthcare professionals are involved in the decision-making process may have the potential to impact how morally complicit such professionals feel around informing service users about abortion, the type of information they wish to pass on, and the impact an objection or the advice given could have on a service user.

Most participants decided that they wanted to access an abortion before they approached a healthcare professional and did not present their abortion as a difficult choice to make. Many participants did not discuss the decision-making process, instead they presented their reasons as absolute. Ashley and Lauren went one step further, commenting, "[i]t was clear from the start I was going to have one. It was never a question" (Ashley) and "making the decision itself was relatively easy. There was no part of me that had any doubts." This implied that healthcare professionals were not a large part of the decision-making process in terms of providing information on the options available, or guidance to help participants decide whether they should abort. It could be argued that informing a service user and not providing details of alternative pathways such as adoption should not be on a healthcare professional’s conscience – contrary to Minerva's (2017) stance – as service users do not use their guidance to decide whether to abort or learn about abortion as an option from healthcare professionals.

On the other hand, Lauren stated that she attended a family planning clinic prior to deciding whether she wanted to abort to discover what options were available to her, although she did not comment whether the healthcare professionals influenced her decision. She decided that she wanted to have an abortion before she approached her GP, indicating that she believed that a decision had to be made before she attended a GP appointment. Thus, she viewed the family planning clinic as a service to access information and the GP as a route to abortion.

In addition, the majority of participants who were unsure whether they wished to abort or not when they approached a healthcare professional were coerced into an abortion, or experienced parental pressure. Family members (parents or partners) were more influential in the decision to abort than healthcare professionals. Aisha’s comments exemplified this as she stated, “I went to my GP. It was kinda like ‘It’s your choice’. It was a very difficult choice. A very very difficult decision […] My parents found it embarrassing, disrespectful. They wanted me to have an abortion. It was difficult. It was an awful experience”. Moreover, it appears that coercion could be problematic around the decision to abort, and an issue that requires further attention. Coercion potentially has ramifications for conscientious objection, as healthcare professionals may not wish to refer or provide abortion without effective policy and guidelines around abortion and coercion.

Keeva presented an extreme case of a healthcare professional influencing a service user’s decision to abort. She attempted to access an abortion in NI in 2019 when abortion was prohibited in most circumstances. Keeva did not fit the legal criteria to access abortion; therefore, her GP could not refer her within NI. However, he could have given her information on how to obtain an abortion in England or Wales, although he may not have been aware of his right to do so (Gentleman, 2017). Instead, the GP actively sought to alter Keeva's decision to abort by referring her to a counsellor, thus challenging her initial decision. The actions of the GP, the counsellor, and her friends led Keeva to keeping her pregnancy and having the child, as she stated, "[h]e referred me to a counsellor. I talked to my friends those who have been in my shoes. They advised me to keep it". It could not be assumed that Keeva did not abort solely due to the actions of the GP. However, it seemed likely that his involvement altered her decision as she clearly wanted to access an abortion when she first approached him, as she stated that abortion was her only option. This elucidates one of the issues that could have occurred circa 2020 in NI before the law on abortion was altered. Such treatment may still be occurring, as one current blog written by a Northern Irish GP states that he would refuse to refer a service user; instead, he would encourage them to have a scan, offer them an appointment with the Early Pregnancy Clinic and provide the details for abortion counselling (SimpleGP, 2019).

Lastly, when Katie approached a doctor in a Welsh hospital, he actively tried to persuade her not to have an abortion. He provided inaccurate medical advice as he presupposed that having an abortion would affect Katie's fertility later in life and could damage her womb. This treatment was negligent because false information was given. The NHS guidelines clearly state that having an abortion does not impact the likelihood of becoming pregnant in the future nor the ability to carry another pregnancy to term without issues. However, there is a small risk that something could go wrong, as in all medical treatment (NHS, 2020, April 24a). Thus, Katie's doctor overexaggerated the risks of abortion. Also, he introduced his own morally grounded belief, as he explained to Katie that she may feel like she had killed someone should she go ahead with the abortion. This belief was based upon moral rather than medical grounds and could have caused distress and impacted Katie's decision to abort. The GMC clearly states that "[y]ou must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that […] are likely to cause them distress" (General Medical Council, 2020b, para 54). Thus, it can be argued that the doctor acted negligently by providing unsolicited moral opinions and medical misinformation to alter Katie's decision to abort. However, this did not impact Katie's trajectory as she still decided to access abortion.

Healthcare Professionals Navigating the Conditionality of Abortion

In Britain service users reasons for accessing an abortion have to be assessed by two doctors in good faith before the service user can access an abortion. There seems to be a notable discrepancy among GPs with regard to assessing service users reasons for seeking an abortion. While some GPs delve into the underlying reasons behind the decision to abort, others may not actively engage in these discussions, potentially leading to varying access to abortion. Janie, Tia, and Kathy's experiences exemplify this contrasting treatment as Janie explained to her GP that she "wanted to go back to school, [and i]t wasn't a good enough reason as to why I was seeking the abortion." In this instance Janie's GP expressed scepticism regarding the validity of this reason. The GP questioned whether academic pursuits were sufficient grounds for aborting. On the other hand, Tia stated that "[w]ithin five minutes I had agreed the route I was going to take. It was really quick, no 'are you sure?' I didn't want to ruin my A-levels. Or my chances of going to university." Tia also expressed a concern about how her academic pursuits could be compromised if she chose to continue the pregnancy. Interestingly, the GP in this case, did not challenge Tia's reasons or seek further clarification. The quick acceptance of her decision may indicate that the GP perceived these reasons as acceptable and legitimate grounds for aborting. Similarly, Kathy also gave a description of the encounter with her GP and remarked that "[t]here was no discussion", implying that the GP accepted her reasons immediately, or did not question them at all.

In contrast, Harshil and his partner were seemingly refused an abortion within the legal gestational limit. His commentary around this makes it seem like it was the gestation that was challenged as he stated "[w]e tried consulting private clinics. Even they were not taking this forward because it was twenty plus weeks. They felt it could be harmful." This situation could represent how doctors judge reasons for accessing abortion differently depending on the gestation. However, it could also present a case that was over 24weeks as Harshil commented that he was not aware of the law in Britain and gave the vague gestation of "twenty plus weeks". He also commented that it could have been due to the health of his partner, though he did not elaborate on this. I could not reach firm conclusions without further information from the health care professionals involved in Harshil's case.

Transparency Around Healthcare Professionals' Decision-Making

Whether healthcare professionals should inform service users of their objections and go into detail and give an explanation for their objection has been debated in the literature (Antommaria, 2010; Brock, 2008). In the UK, guidelines stipulate that doctors must inform the service user that they do not provide abortion care without causing service user distress. They are able to discuss the reason for their objection if they wish so long as they do not imply judgement of the service user (General Medical Council, 2020b).

Several participants were confused whether their circumstances represented a conscientious objection due to lack of transparency around decision-making among healthcare professionals. At first glance, Harshil's experience could have represent a case of a healthcare professional objecting, as BPAS and the hospital in England refused to perform an abortion, despite Harshil's claims that the pregnancy was "pretty much fine and normal". However, I questioned this further and it seemed that the abortion was not supported in the UK due to the health of the pregnant individual and/or the abortion gestation, as it could have been over 24 weeks when the second healthcare professional was approached. Similarly, Jennifer was told that she would have to have someone to accompany her through the abortion process – the way she framed this made it seem as though it was due to a conscientious objection, and the healthcare professional believed she needed help in the decision-making process. After we discussed this further, it became apparent that she needed someone to accompany her due to the hospital's policy as she would have needed assistance and to be escorted home after the procedure. Rosanna, however, was left confused as the nurses looking after her claimed they could help her but they would not: "[t]hey wanted to examine inside, 'I won't perform that on you'. She said

‘I can, but I won’t’. It was just very confusing – very unclear. The nurses went behind the curtain and started whispering”. It was not made clear to Rosanna whether the nurses’ actions were for reasons based on conscience or because they were not medically trained to deal with Rosanna’s tilted uterus as a doctor soon came to her assistance.

In Keeva’s case, she attempted to access an abortion before 2019 in NI. At that time, doctors were legally able to inform service users of abortion services in England and Wales and did not have to refer them for counselling (Gentleman, 2017). However, the doctor whom Keeva approached referred her to counselling, which could indicate – but not confirm – that the doctor had a conscientious objection. However, it could also highlight the confusion many healthcare professionals felt at this time, as it has been reported that it was not clear how abortion should be navigated to prevent persecution (Gentleman, 2017). Janie attempted to access an abortion by attending a hospital that did not provide abortion services, as not all hospitals specialise in abortion. She was referred to another hospital which initially refused to provide her with an abortion because her reason for wanting to further her education was not deemed acceptable. She was told to return in a month’s time, which she did and stated that she wanted to have an abortion for health-based reasons, a reason that was seen as acceptable. It was not clear to Janie whether the healthcare professional was acting in compliance with the law or because they personally did not believe the reason she gave was sufficient.

Thus, participants were often confused over whether their lack of smooth access to abortion was due to an objection, as there was no clear communication from healthcare professionals why their access was being interrupted or transferred to someone else. It was not clear if they had considered whether it was due to conscientious objection before the study. Nevertheless, service users were left confused, scared, and sometimes alone; for example, Jennifer proceeded to have a medical abortion at home.

Reflective stop-off:

I was not aware if participants had considered whether their lack of smooth access to abortion was for a conscientious reason before their involvement in my programme of research. On reflection, if I were to repeat this study, I would place more emphasis on discovering their views at the time, rather than their views on knowing what conscientious objection is in retrospect.

The five participants who experienced a clear conscientious objection commented on whether healthcare professionals informed them of their objection. Charlie explained that her GP informed her of her objection, stating that “she did tell me that she did not agree with it, because of her background, her beliefs.” Thus, Charlie was aware that her GP was objecting on non-medical grounds and it was due to her beliefs; this is in line with guidelines (General Medical Council, 2020b). Charlie commented that she respected her GP’s decision – the clear communication and reasoning could have aided this, although it cannot be assumed that Charlie would not have respected her without this. Katie was also informed by the healthcare professional as to why he could not be involved in her abortion: “[i]t was his personal beliefs. He felt it was like killing. He said he's a religious man. His faith could not allow him”. However, this was followed up by an attempt to change Katie’s trajectory to prevent her from having an abortion. Thus, the healthcare professional went further than outlining and explaining his own beliefs, and went against guidelines (General Medical Council, 2020b).

However, not all participants understood why their healthcare professional objected, although they knew their objection was not based on medical reasons or concerns. For example, Emma stated, “I'm not sure if hers wasn't relevant for religious view”. This indicated that Emma could not pinpoint why her GP was objecting, though she believed it was not for religious reasons. This opinion may have been fuelled by the fact that Emma’s GP was pushing for her mother to be involved in the decision-making process. Emma may have believed the GP’s objection was based on her (Emma’s) age and the fact that the GP knew her and her family. Jess also made assumptions as she stated “I'm just assuming religious reasons. But I could be wrong”. Jess reached this conclusion after her GP sat in silence after he commented that he could not be involved. This reinforced the assumed association between religion and conscientious objection. Finally, Maria commented that she was aware that her GP was strongly religious, although she did not elaborate on how she knew this.

Overall, it seems that healthcare professionals need to be more transparent in their decision-making, regardless of whether this is due to conscientious objection to prevent confusion on the part of service users. Many participants were left perplexed when healthcare professionals were not clear why they were making certain decisions, which could lead to disastrous consequences. Moreover, both a lack of transparency and oversharing one's opinion and passing judgement went hand in hand with improper treatment that went against guidelines (General Medical Council, 2020b). I explore this treatment in the section titled 'healthcare professionals navigating conscientious objection'.

Service User Treatment by Non-objecting Healthcare Professionals

Previous research has uncovered mixed treatment from service users in relation to their abortion care in England (Whitehouse et al., 2021). Participants in my study encountered a range of healthcare professionals and had both positive and negative experiences. Those who had more positive interactions with such professionals commented that they were supportive and friendly (Aisha), professional (Lauren), and non-judgemental (Jane). Dani presented an example of fair treatment when she related that "[t]he first woman did a scan. She was lovely. She never said 'what would your family think? Are you sure you wanna do this?'" Dani paired good treatment with healthcare professionals who did not question her decision to abort, as she had clearly made up her mind at this stage and had already put her reasons across to the doctor/s who had signed the HSA1 form.

However, not all participants' experiences were as positive. Firstly, Diana explained that when she returned for a check-up post-abortion, she was seen by a young physician, and went on to say that "the way he treated me was very rough. I just knew he disagreed with abortion. There was judgment there". Nadia also had an unpleasant experience with a healthcare professional, stating that “[t]he woman who did the scan knew I was having an abortion. She was still showing me everything. I really struggled with it”. Similarly, Holly shared her experience of the anaesthetist judging her for her abortion as she went under he commented on her profession, inferring that midwives should know better and should not access abortion. Amy also indicated that she had a negative experience, as after her abortion she asked a healthcare professional, “‘where’s my child?’ She turned around and said to me, ‘You silly girl, don’t you know what you have done’”. The experiences of Diana, Nadia, Holly, and Amy could reflect encountering healthcare professionals who do not agree with abortion for conscientious reasons. However, these professionals did not object and refuse to take care of service users; therefore, I cannot label these healthcare professionals conscientious objectors.

Participants who attended specialised abortion clinics also reported negative experiences. Rosanna attended a BPAS clinic and explained that “the lady who did the sonogram. She told me to lie down, was really stern. I was getting visibly upset. I just wanted her to stop. I kind of just persevered”. This aligns with Whitehouse et al.'s (2021) findings, as service users in their study commented that staff interactions were either the best or worst thing about their experience.

Understandably, the negative actions and comments of non-objecting healthcare professionals had a negative impact on participants’ emotions. For example, when talking about the actions of the anaesthetist, Holly stated that “[i]t really affected me”, and Nadia commented that she struggled after being shown the ultrasound scan. Neither Holly or Nadia elaborated on these comments. Also, Diana commented that the rough treatment she had received from the young male doctor had “stayed with me as long as the after effects of the abortion”.

Although the conscience clause attempts to remove healthcare professionals who are unable to provide service users with empathetic and equitable care due to their conscience (Pellegrino, 2002), it seems that negative treatment and stigma within the health service is an issue that needs to be addressed. More education around the conscience clause could prevent this treatment - to some extent - by healthcare professionals who are not aware that they are able to object. However, it cannot be assumed that all healthcare professionals who treat service users unfairly have a conscientious objection. Thus, further measures need to be taken to provide equitable, respectful, and non-judgemental care for all.

Issues with Service Delivery

Participants negative experiences were not always directly linked to one doctors actions, but wider issues with service delivery. Kathy described that she was in pain after her abortion commenting it was "just something I can't put into words. I couldn't stand up." This indicates that the management of pain for service users may not always be effective. This could reflect the ineffective treatment of women's pain due to gendered bias around pain management, which is even more prominent and problematic for women of colour (Hampton et al., 2015). This experience may have contributed to Kathy's anti-abortion born again Christian stance. Participants also commented that they had been placed on a ward with individuals who had given birth, or who has miscarried, this created negative emotions such as guilt and disgust. Sarah explained that "you get put on an antenatal ward after. Which was the most upsetting thing. There's people with their babies. You feel a bit disgusting." Thus, these two aspects of service delivery need to be examined to improve the service user experience when aborting.

Healthcare Professionals Navigating Conscientious Objection

In the UK, objecting doctors are not only obliged to inform service users of their objection, but also of their right to discuss their condition and treatment options with another healthcare professional who can advise them on abortion (indirect referral). Furthermore, the objecting doctor must ensure that the service user has enough information to make another appointment to see a non-objecting doctor. If it is not practical for the service user to make arrangements to see another doctor, the objecting doctor must make immediate arrangements for a qualified colleague to refer, treat or advise the service user. Above all, doctors must not obstruct service users' access to abortion (General Medical Council, 2020b).

Charlie received care from her GP that met (and went beyond) these guidelines as the GP told her that she could not facilitate her abortion as it was against her beliefs. The GP then directly referred Charlie to another GP who could provide her with an abortion. Charlie explained that "[i]t was handled in a very sensitive way", indicating how the middle-ground approach (Wicclair, 2011) could work in practice.

However, Katie, Jess, Maria, and Emma were not informed of their right to speak to another healthcare professional regarding accessing abortion. Maria inferred that abortion was not outlined as an option by her GP as "[t]hey weren't on board. My answers were very much contested". Similarly, Emma's GP focused on what her mother would think and that an abortion was not Emma's only option. When Emma asked her GP to refer her, she was informed that "everyone's busy" (GPs at the clinic) and to "just look online". Moreover, Jess explained that her GP would not even have a discussion with her, he said "I can't do that for you" [and] "That was it". Finally, Katie's GP gave her medical misinformation and views from his own moral stance, although he did refer her to BPAS. Katie inferred that it was her assertiveness that pressured the doctor into doing this. Thus, discussing abortion with another healthcare professional was not presented as a legitimate option for Maria, Emma, Jess, or Katie and the doctors' actions can be seen as an obstruction to accessing abortion. This reflects other UK-based findings (Finnie et al., 2006; Kumar et al., 2004) which have revealed that objecting healthcare professionals sometimes avoid discussing the available options with service users and leave them uninformed.

In summary, the commentary of participants (service users) makes it seem that healthcare professionals are either not aware of their obligation to inform service users of their right to see another professional to discuss obtaining an abortion and not to obstruct access, or they are aware but choose not to follow policy and guidelines. Moreover, I believe that there needs to be more education regarding the process of how healthcare professionals should navigate conscientious objection, and more regulation to ensure they are doing so.

Service Users Navigating Conscientious Objection

In line with policy and guidelines, healthcare professionals should not leave service users without anywhere to turn (General Medical Council, 2020b). Charlie's GP referred her to another healthcare professional to provide her with an abortion, and the doctor Katie approached referred her to BPAS. However, Jess, Maria, and Emma had to navigate accessing abortion alone. Emma decided to telephone and book an appointment with a different GP at the same surgery. While she was still present at the surgery, Jess made an appointment with the receptionist to see a different GP. This reinforced the perceived importance of GPs that I discussed previously, as well as the lack of options and education the participants may have had. Maria did not return to her GP, instead she contacted a reproductive clinic herself, but did not explain why this was not her initial choice. Thus, all participants were able to access an abortion and in this sense were not actually left without anywhere to turn. However, participants often felt isolated and as though they had nowhere to turn, as I discuss in the following section.

Impact of Conscientious Objection on Service Users

The way in which the healthcare professionals conducted themselves had an emotional impact on four of the five service users who experienced conscientious objection. In Charlie's case, she was not emotionally impacted by the actions of the healthcare professional as she commented, "[t]he process itself was traumatic. Not because of the professionals involved, because of the circumstances". Charlie found the process traumatic, and she had been raped which meant that in addition to the emotional impact of experiencing rape, she had to navigate rape counselling services while accessing abortion. Charlie was referred and informed effectively, and this did not have an emotional impact on her or alter the type of abortion accessed as she stated, "within a week it was resolved […] I was eight weeks so I just took the tablets". This provides an example of the successful implementation of the middle-ground approach (Wicclair, 2011).

However, the impact that the healthcare professionals' actions had on Katie, Jess, Maria, and Emma were detrimental to their emotional well-being and added pressure on them to navigate accessing abortion alone. Jess explained that "I started crying. I was already feeling really distressed. I just wanted to get out of there. It was absolutely horrific". It was obvious that the GP's actions of stating he could not do anything for her and sitting in silence had a huge negative impact on her emotional well-being as she described the appointment as "horrific", and it brought her to tears. Maria was frustrated and concerned with how she would access an abortion as she commented that "I was scared that's going to be the reaction everywhere. I was upset having to answer all those very personal questions. It was quite frustrating". In addition, Emma's commentary revealed that she was agitated and worried about how to access an abortion as she asked for this information to no avail. She found the lack of information discouraging and questioned whether she should even have an abortion. This indicates the potential impact healthcare professionals could have on a service user's decision, although Emma was still able to access abortion services. Similarly, Katie also questioned whether she should have an abortion, "I had second thoughts at some point" and was worried about where she could obtain one: "I did not want to have the later consequences of having the abortion in the wrong way, the wrong place. I wanted him to help me even if he couldn't himself". Thus, the emotional impact that healthcare professionals actions had on these participants was unacceptable, negligent, and contrary to current guidelines (General Medical Council, 2020a). My findings reflect those of Finnie et al. (2006) whose participants in Durham, England commented that objecting GPs caused emotional distress, while Biggset et al. (2020) identified a positive correlation between barriers to abortion and anxiety symptoms.

However, all the participants managed to access abortion in a timely manner. Charlie was referred to another GP within a week and Katie was referred to BPAS after two days. Emma had to wait two weeks for another GP appointment – fortunately this did not impact the type of abortion she accessed as she was still in her first trimester. Jess and Maria did not comment on how long it took for them to see another healthcare professional. Thus, conscientious objection did not prevent service users from accessing abortion or seemingly alter the way in which they chose to abort. However, this may not always be the case, and the unnecessary emotional impact of waiting longer to access abortion needs to be considered. Previous research has failed to address whether conscientious objection has prevented service users accessing abortion, as UK-based research recruited participants from abortion clinics who had already accessed an abortion (Finnie et al., 2006; Kumar et al., 2004).

Conclusion

I have illustrated that service users may not be aware of the self-referral routes to abortion, thus putting additional pressure on GPs whom participants viewed as an appropriate route to accessing abortion. Therefore, the conscientious objection clause may not be bypassed to the extent statistics imply. Furthermore, there is no typical abortion journey, as participants had varied experiences of treatment from objecting and non-objecting healthcare professionals. In most cases they had decided that they wanted to access abortion before approaching a professional. This could be important regarding how morally complicit healthcare professionals feel when informing service users of their right to an abortion, the information they wish to pass on, and the impact an objection and the advice given could have on a service user. There was a lack of transparency around the decisions made by both objecting and non-objecting healthcare professionals, which left participants confused. Of the five objecting healthcare professionals, one referred and informed the participant and did not act judgmentally or insensitively, indicating how the middle-ground approach could work in practice. However, the other four participants who experienced conscientious objection did not receive acceptable treatment as they were not informed of their right to see a non-objecting healthcare professional, and because the professionals attempted to obstruct access. This treatment was detrimental to the participants' emotional well-being, although all were able to access abortion in a timely manner. I make suggestions for policy and guidelines and further research in Chapter Six.

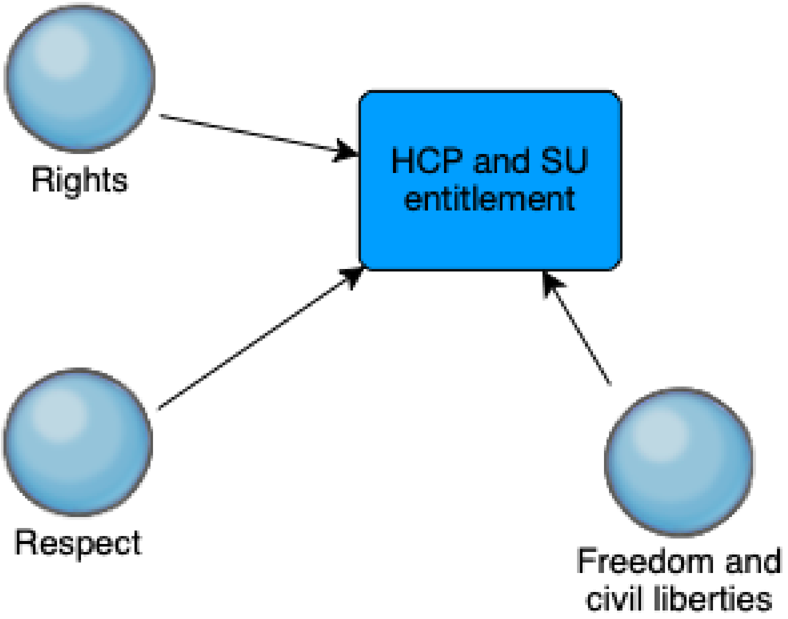
In the following chapter, I present the participants’ views on conscientious objection, I analysed these using a reflexive liberal feminist thematic analysis.

Chapter Five: Reflexive Liberal Feminist Thematic Analysis of Participants' Views on Conscientious Objection

In the following analysis, I adopted a liberal feminist approach by focusing on power along with participants' opinions of conscientious objection law and practice and whether these need to be changed, as well as how these should be changed to improve the situation for service users. I drew upon Wicclair's (2011) three positions of the incompatibility thesis, middle-ground, and conscience absolutism to understand where participants sat in relation to this framework. I established five main themes (using the reflexive liberal feminist thematic analysis presented in Figure 3, Chapter 3): healthcare professional and service user entitlement, contextualising conscientious objection, the impact of conscientious objection, the nature of conscientious objection, and organisation of conscientious objection. I present these themes in Figure 5.

Healthcare Professional and Service User Entitlement

Figure 4: Theme one: healthcare professional and service user entitlement



Rights

Liberal feminism is concerned with individual rights and equality. In the context of conscientious objection, a liberal feminist account would endorse policies that balance the rights of both service users and healthcare professionals, allowing the latter to maintain their moral integrity and service users to access abortion, provided that the objection does not place an unnecessary burden on the service user, permit unacceptable objections or undermine the reproductive autonomy of the service user (Clipsham, 2013). This approach can be likened to Wicclair's (2011) middle-ground perspective. By contrast, the incompatibility thesis prioritises the rights of service users, as conscientious objection would be disallowed, while conscience absolutism focuses on the rights of healthcare professionals, allowing for objection without informing and referring service users.

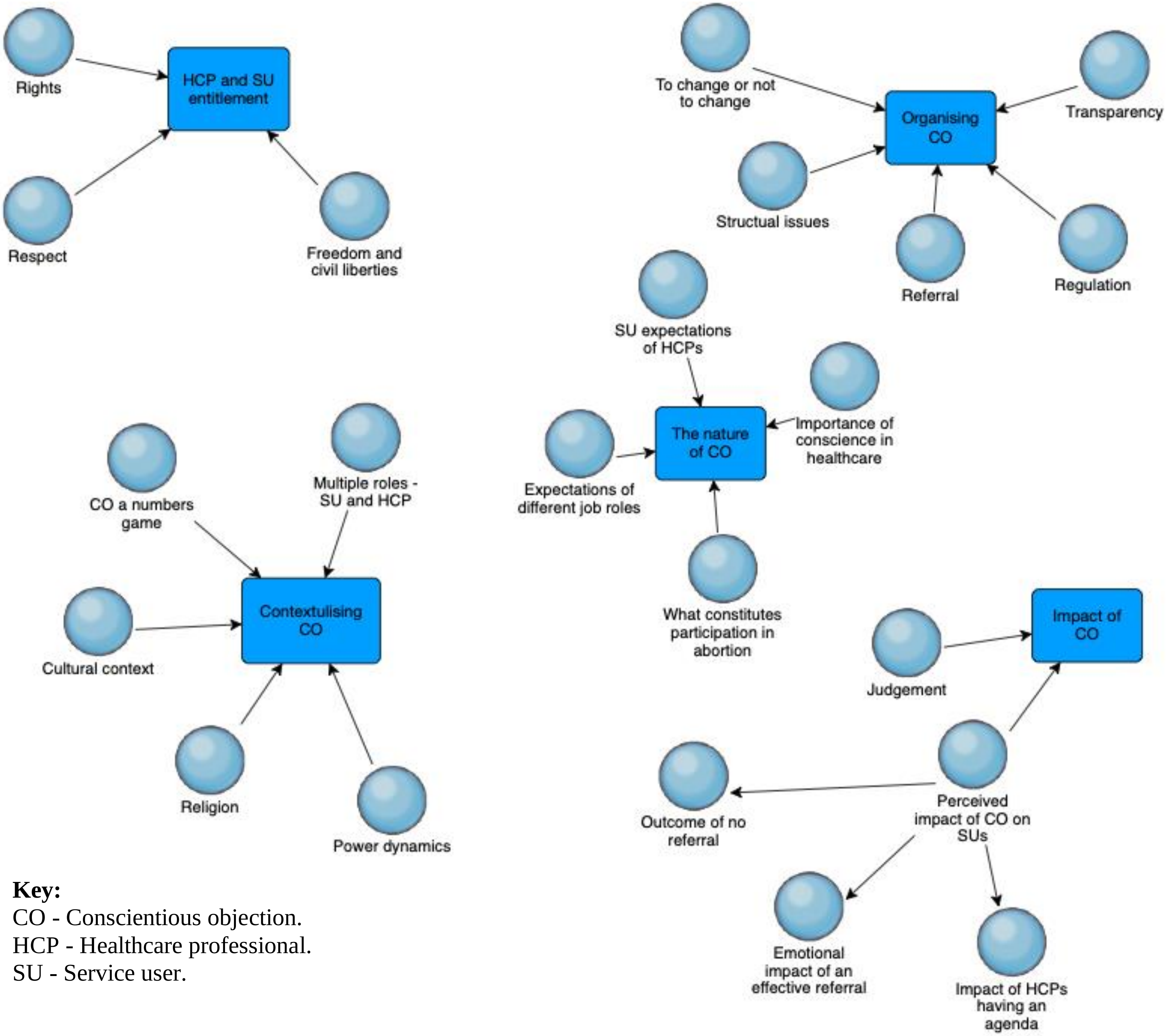
The participants understood and described rights in a variety of ways. Firstly, the right to abortion was presented as an 'absolute' right, indicating that service users should have autonomy and power over their reproductive rights. Pam stated "I mean, in theory I think […] anyone anywhere in the world should be entitled to [abortion]. 'cause there's a, I think, a basic human right now". Although Pam's comment was technically incorrect in the eyes of UK law, as abortion is not an absolute right and rights around abortion have the potential to erode further – with Poland as an example, despite being governed by the European Confederation on Human Rights. Pam illustrated the importance of abortion, and that it should be regarded as a universal 'absolute' right rather than a *de facto* right. The importance of abortion rights is key within the incompatibility thesis and when balancing rights in the middle-ground approach (Wicclair, 2011). Rights to abortion have been noted by many feminist thinkers, including Orr (2017).

Furthermore, institutional conscientious objection was seen as a barrier to service users having their rights to autonomy and healthcare respected. Dani commented that "I feel like people, in these institutions wouldn't even refer out of it. It would sort of be like no, like this is your only option, and that's. Just taking away someone's basic human rights, of deciding what they wanna do, and bodily autonomy." Dani feared the unequal power dynamic, institutional control, and the likelihood that policy and guidelines would not be adhered to within an institution which has an anti-abortion ethos. She framed the culture of abortion within these establishments as inevitably problematic regarding service users' rights.

By contrast, Kathy focused solely on the rights of healthcare professionals without discussing or considering service users' access to abortion and the rights surrounding this. She stated that "[health care professionals] should have a right to - even if they've got no religion – *laughs* […] not have to be involved in that [abortion]". Kathy's perspective aligned with conscience absolutism (Wicclair, 2011), and her lack of consideration for service users' rights may have reflected her self-described anti-abortion and Born Again Christian stance. However, I cannot make an association between the participants' stances on abortion and opinions on conscientious objection more generally, as other participants did not fit this ideal, suggesting one's stance on abortion is not always integral to their opinion on conscientious objection (Campbell, 2011).

However, most of the participants considered the rights of both service users and healthcare professionals. Rejecting the notion that conscientious objection has to be a zero-sum game and supporting the liberal feminist middle-ground approach of balancing rights (Campbell, 2011), Holly commented "I believe in the right to choose, and I think there must be a way forward, from the impasse in certain countries now. Where everybody's [health care professional and service user] right to choose can be facilitated and accommodated". Participants also elaborated that service users' rights are paramount when balancing rights and that conscientious objection should not impact their right to abortion. As Pam stated, "as long as it doesn't impact the patient at the end of the day, as long as they get what they're entitled to within the country they're in". This reflects the outcome-based approach presented by Wicclair (2011) and Brock (2008) who claim that conscientious objection should only be allowed if no undue burdens are imposed on service users.

Figure 5: Reflexive liberal feminist thematic analysis themes



Key:
CO - Conscientious objection.
HCP - Healthcare professional.
SU - Service user.

Moreover, the participants presented all three of Wicclair's (2011) approaches when discussing rights. The incompatibility thesis was present as abortion was seen as an absolute right that should be facilitated by healthcare professionals because it triumphs over their right to object. Conscience absolutism was present as participants believed that healthcare professionals' rights should be paramount, failing therefore to focus on service users' rights. Finally, participants discussed balancing both service users' and healthcare professionals' rights, but giving service users' rights precedence, thus supporting the middle-ground approach.

Respect

Respect was an important concept when the participants were making sense of conscientious objection. Firstly, the participants believed that healthcare professionals' religious and personal beliefs should be respected, counter to the incompatibility thesis (Wicclair, 2011). Katie exemplified this by stating "I think ok for, for all of them [(health care professionals)] it should be respected. 'cause everyone has his own personal beliefs and maybe their religion, […] their culture […] So I think it should be respected". Not only did Katie highlight the importance of respect, but she also gendered the service user and healthcare professional relationship, labelling the professional as male. This endorsed traditional gender stereotypes, power relations, and the paternalistic nature of healthcare. However, Katie did not reflect on how – or if – the gendered element she implied would impact the respect healthcare professionals deserve.

Moreover, respect was presented as a two-way process between service users and healthcare professionals that should be supported by law and policy. Thus, it was believed that such professionals should respect the healthcare choices and decisions made by service users to abort, regardless of their opinion on abortion and the position of power they hold, while service users should respect healthcare professionals' beliefs, opinions, and decision not to be involved in their abortion journey. Harshil made this evident by commenting, "we respect them so they should respect us". Lauren also exemplified mutual respect by stating, "you've got to kind of respect, each individual's wishes whether you know, it's a person seeking support, or it's the practitioner if they. If they don't want to do it, then that's ok”. The notion of mutual respect is supported by the middle-ground approach (Wicclair, 2011), which has been voiced by UK midwives (Maxwell et al., 2022) and can be seen in practice in Charlie’s abortion journey. Charlie described a feeling of mutual respect between herself and her GP. She indicated that this contributed to the smooth experience when her GP objected, stating, “I respected her decision, and she respected mine”. Charlie thus respected the GPs decision to object, while the GP respected Charlie’s need and decision to have an abortion.

Notably, respect was not allocated by participants based on job role, gender, or other intersectionality, but based on personal belief, religion, culture, and accessing services. Participants saw respect on two levels, respect for healthcare professionals as essential, and respect as a two-way process which should be integral to deciding how to navigate conscientious objection. All participants understood why healthcare professionals would object and respected this, though not all agreed that it should be accommodated.

Freedom and Civil Liberties

The participants felt that laws protecting a healthcare professional’s freedom to object were of upmost importance and that these civil liberties should be protected. For instance, Amy commented that “you should have freedom of expression. Erm, being able to express yourself in your speech. The freedom to express yourself in the various forms our law, our countries allows us to. Individuals should be able to object if they don’t feel comfortable”. Freedom of speech and expression were seen as important universal rights that should be protected and facilitated by democracy, as endorsed by Ceva (2015). Freedom to challenge dominant hegemonic ideology was also seen as an important right and aspect of free speech, as expressed by Ashley: “I guess I'm I'm talking now, less in the framework of having an abortion, but more in general, like the ability to object. I think, you know, that is an important thing to be able to, have some kind of accountability within things. And you know, to have people that might stand up for things or whatever, but in the circumstances of just on like a moral. Or ideological standpoint”. However, Ashely’s commentary on the freedom to object was more general, rather than specific to abortion. This could have reflected her pro-choice stance, as she may have feared that if abortion were challenged in this way it could become less accessible and not seen as a *de facto* right, which would have ramifications for the power and choices service users have in relation to abortion care.

Furthermore, Amy took the protection of healthcare professionals' freedoms one step further by arguing that institutional objection allows professionals to work in an environment that protects their core values. Thus, disallowing institutional conscientious objection would remove freedom and autonomy from healthcare professionals. She asserted the following: "that's the, moral ethos they hold. So it's just like any other establishment. […] if you don't allow people then to express that. You are taking away their freedom of expressing… their belief. I mean because, in the same way that you have establishments that totally don't agree with it, you have some that are totally fine with it". It was important to Amy that healthcare professionals are given the option to work in an environment that supports their individual beliefs and values, as this was seen as essential in protecting their conscience and ensuring they are not morally complicit in abortion. This resonates with debates in the academic literature as Wicclair (2011) argues that institutions have an identity and integrity to protect and uphold, which in turn protects individuals affiliated with the institution. Cowley (2017) develops this argument further, claiming that healthcare professionals are less morally complicit when working within objecting institutions as they are not freeing up time for abortion providers.

However, Emma disagreed that prohibiting conscientious objection in general would remove healthcare professionals' freedom and expression, thus supporting the incompatibility thesis (Wicclair, 2011). She claimed that "some people might interpret it wrongly, and say that, I'm taking away their, you know, freedom of speech. It's very difficult to to say, to discuss these things. Especially in the view of religion, a lot of people might say, oh, you're stopping me from expressing my own belief, or like, something like that". The basis of Emma's argument was perhaps drawn from the stance that healthcare professionals have the freedom to enter and leave healthcare when they choose, and that professionals are in a position of power over service users (Shahvisi, 2018). Thus, they can protect their conscience by choosing not to enter the health service and hence, conscientious objection should not be allowed (Munthe, 2017).

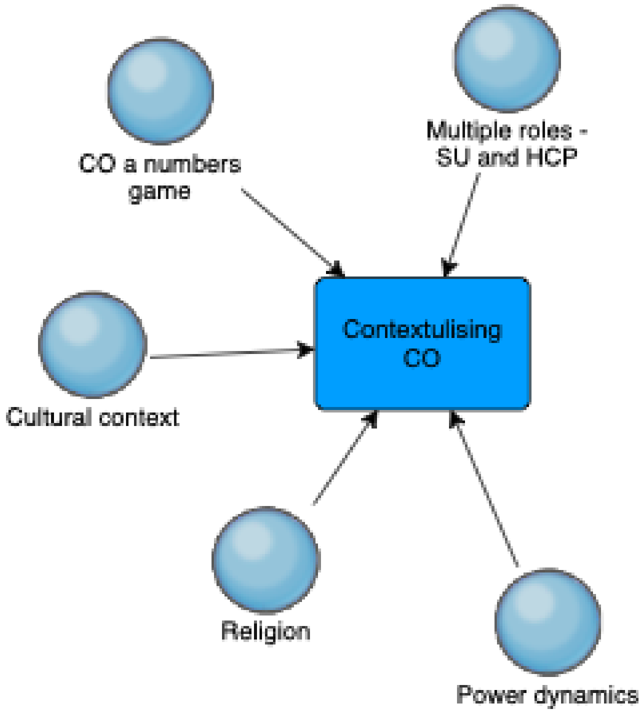
Also, Maria believed that if healthcare professionals exercise their freedom to object, the freedoms of service users are removed. She made this evident by stating, “[y]our freedom ends where someone else’s freedom starts”. This argument supports the incompatibility thesis (Wicclair, 2011), as it implies there is a battle or resistance of freedom between service users and healthcare professionals. This mirrors Campbell's (2011) argument that conscientious objection is often presented as a zero-sum game with regard to the rights of healthcare professionals and service users. Though it is important to note that Campbell debunks this presentation and does not support it.

However, there was a strong belief that healthcare professionals should abide by policy and guidelines around conscientious objection to ensure service users’ outcomes are successful and that they can access abortion. Two participants went as far to say that law and policy are so important that healthcare professionals should only object if the abortion goes against UK law or policy; for example, if the gestation is over 24 weeks. This is effectively stating that conscientious objection should not be allowed, and that morality and medical safety should be dictated by law. This removes any power from the healthcare professional to make decisions around morality and abortion, as it was implied that rules should be followed without question. For instance, Harshil commented, “[t]o be honest I don’t really think they should be able to object, unless it is against law or policy”, while Keeva stated, “[t]hey need to look at […] what the law says about it”. Both Keeva and Harshil put faith in law and policy, dictating what is morally acceptable regarding abortion. These opinions could be based on the importance of democracy in creating law and policy and the notion that healthcare professionals are actors of the state who have a contractual duty and have been given power to help service users, as endorsed by Rhodes (2006).

Freedom and civil liberties themselves were presented in a variety of ways. Most participants highlighted the importance of allowing healthcare professionals to object and that this should be protected in law. However, some participants also believed that giving healthcare professionals such freedom removes the freedom of service users due to the unequal power dynamic that exists and the extent to which service users rely on such professionals. This stance supports the incompatibility thesis (Wicclair, 2011) that conscientious objection should not be allowed and that healthcare professionals should follow hospital policy.

Contextualising Conscientious Objection

Figure 6: Theme two: contextualising conscientious objection.



Religion

Religion is often presented in the literature as intrinsically linked to conscientious objection (Meaney et al., 2012; Minerva, 2015; Pellegrino, 2002; Savulescu, 2006) and religious beliefs and conscientious objection are terms that are often used interchangeably. Thus, religion is often described when contextualising conscientious objection. Participants' comments resonated with this as they often used the term 'religious beliefs' when discussing conscientious objection. However, Tia commented that religion is not the only reason why healthcare professionals may object as she stated, "'cause you see it's not just religion, is it? It's a whole other load of things". Nevertheless, religion was seen as one of the main reasons why healthcare professionals' object.

Notably, participants often reflected upon their own lack of religiosity to explain why they could not understand conscientious objection. Emma, for instance, stated, "I'm not sure, if I speak for all the Christians, I don't know, I'm not really religious myself", while Tia explained that "obviously I'm not religious, sooo it's really difficult [to understand]". This reinforced the belief that religion is one of the main reasons why healthcare professionals object, as presented by Fink et al. (2016), Freeman and Coast (2019), and Nordberg et al. (2014).

Furthermore, conscientious objection on the grounds of religion was justified by discussing the opinion that life begins at conception and the sanctity of life, as Nadia commented that "you are part of a certain religion, and, […] you believe all life is precious, and life begins at conception, and all that type of stuff". Further to this, participants claimed that religion is especially important when allowing institutional conscientious objection, as Keeva and I had the following conversation: "Becky: Say it's like a religious hospital, so like a Catholic hospital, do you think the whole hospital should be able to say we don't want to [provide abortion]? Keeva: Ok. Maybe if it is a religious hospital". For these participants, religious reasons for conscientious objection were seen as valid and acceptable, perhaps because they are well-known, understandable debates. However, it is important to emphasise that the UK has very few religious hospitals.

However, not all participants saw religion as a legitimate reason to object. For instance, Jane stated that “I don't think you should be able to put your religious beliefs, into the fact that you're making decisions for anyone else”. She saw healthcare professionals as part of the abortion decision-making process, implying that their opinions could potentially alter the outcome for the service user due to the unequal power dynamic between service users and healthcare professionals, as expressed by Shahvisi (2018). Jane saw this as unacceptable and believed that healthcare should be free from religious bias and opinions. This stance could be put forward by those who support the incompatibility thesis (Wicclair, 2011), and radical feminists would argue that religion should be kept out of healthcare, as they document the association between religion and patriarchy (Jeffreys, 2012; Stopler, 2005).

Nevertheless, participants understood that religious individuals may wish to perform abortions, as abortion is not ‘always a tragedy’ (Love, 2017). For example, Holly commented that “[i]t can be a kind act, an abortion”. She was implying that it can be the Christian thing to do based on her own religious background and professional background as a midwife. This challenges the mainstream rhetoric around abortion, particularly around religion and abortion, and suggests that abortion and religion do not have to be mutually exclusive.

Furthermore, it was evident that religion was envisioned as an acceptable reason to object by some participants, especially in the context of institutional objection. However, this did not go unchallenged, as some believed that religion should be kept out of healthcare and that abortion can be supported by religion.

Reflective stop off:

During the interviews I conducted with participants, their views on conscientious objection were contextualised in relation to the UK. It was not clear whether participants were including NI in these assessments and discussions. Participants may or may not have been aware of the differences in abortion law and practice in Britain and NI. For this reason I have used the term 'UK' in this chapter, as this is the terminology that participants and I used during the interviews. If I were to repeat this study I would outline the differences in abortion law and how it operates in practice in Britain and NI to further contextualise and understand participants views on conscientious objection.

Power Dynamics

Power is an important concept that underpins all feminist research and thought (Hawkesworth & Disch, 2016). The power dynamics present in the UK provide context and understanding to illuminate participants' opinions on conscientious objection. Power dynamics were understood by participants to exist on the following levels: power between the healthcare professional and the service user, power of women in society and the law-making process, power between institutions and service users, shared power/powerlessness as a way of bonding between women, and power bound by intersectionality – although abortion was only presented as a women's issue rather than an issue for non-binary and transgender individuals.

Firstly, participants understood conscientious objection as a gendered issue that impacts women, as Ashley stated, "this issue […] we're talking about is all women you know, like we're not, and no point in this are we ever talking about young men". This opinion supported one of the key drivers of my programme of research and the liberal feminist stance I took, as Ashley also understood that decisions around conscientious objection (including legal decisions) are often made by men, and that this is symptomatic of the patriarchal society we live in, as women and those who can become pregnant are traditionally excluded from the law-making process (Dickens, 2014; Levit et al., 2016; Okin, 2013; Paxton & Hughes, 2007). Diana furthered this perspective as she asserted that "this patriarchal society that we live in makes so many decisions for women anyway, […] let women choose whether they should have an abortion". She argued that if we lived in a matriarchal society, or if men were child bearers, conscientious objection would not be allowed as there are deeper rooted gender issues – related to control – at play.

Diana believed that conscientious objection is a barrier to accessing abortion, and that a healthcare professional merely objecting can change a service user's mind about accessing abortion, perhaps because of the unequal power dynamic that exists, the knowledge held by healthcare professionals, and the perceived authority and power entrusted in such professionals by society, as understood by Shahvisi (2018). She went on to express the same opinion regarding micro level interactions, contending that conscientious objection is a feminist issue as she believed that male healthcare professionals are more likely to object than female healthcare professionals, as exemplified in the following comment: "these decisions tend to be taken by men. […] I'd be interested to know in the study how many female doctors conscientiously object [in] comparison to how many male doctors conscientiously [objected] and 'cause I've got a feeling it's gonna be a big difference". Diana explained the traditional stereotypical power dynamic of male healthcare professionals controlling the health outcomes of female service users as being due to the paternalistic and patriarchal nature of healthcare. Thus, she argued that conscientious objection policy, law, and the individual actions of male healthcare professionals remove power and autonomy from female service users.

Moreover, institutional conscientious objection was framed as an extension of patriarchy and control that removes autonomy and service users' choice to abort, as indicated in the following conversation that I had with Diana: "Becky: Some countries like Italy and America. They let whole institutions object, so if they have like a Catholic hospital, the whole hospital will be able to object. Diana: Yeah, I'm a feminist and I see this, especially with abortion. As a way of controlling women even further than what they're already controlled within society". Again, this reflected the opinion that conscientious objection is a form of control and a barrier to accessing abortion, as expressed by those who support the incompatibility thesis (Fiala & Arthur, 2014, 2017a, 2017b; Giubilini, 2014, 2017; Johnson et al., 2013; Savulescu & Schuklenk, 2017; Schuklenk, 2018; Schuklenk & Smalling, 2017). Thus, power dynamics were expressed from a radical feminist approach that framed conscientious objection as a zero-sum game (Campbell, 2011).

Notably, several participants discussed the relationship and connection women have with one another, implying that women have loyalties to one another because of their gender and their experience of the social world. Jess described how she felt about female healthcare professionals objecting: “[e]specially as a woman, you know how stressful it can be. Why would you do that to another woman? Why would you, you know? Just say no”. Jess envisioned a shared world view and understanding between women, very similar to Oakley's (1981) conception of sisterhood (now revoked). Thus, she argued that womanhood is universal and that female healthcare professionals should have a shared understanding of what it means to be a woman. This world view also built upon the stereotype that women are innately caring and understanding, whilst presenting conscientious objection as problematic and a barrier to access.

By contrast, Ashley framed her opinions from an intersectional perspective, explaining that being a POC and a female negatively impacted the healthcare she received. She then reflected upon the systemic power imbalance faced by women of colour and those in poverty more generally, stating, “[i]t's not just someone just refusing… personally, as a young woman of colour. I don't have good experiences with healthcare professionals, because. They just, you know, for whatever systematic reason, they cannot. Adequately deal with my needs, first and foremost […] the system is skewed, and is negatively impacting minority women. Or, women in poverty’. This opinion challenged the assumed universality of womanhood presented by Jess, and indeed Oakley (1981); instead, Ashley adopted an approach that understood the impact of factors and identities other than gender, very similar to Phoenix's (1994) criticism of Oakley’s former work.

Furthermore, most participants presented women as marginalised individuals within healthcare, and in society more generally. This was often viewed as universal and static without an intersectional lens. Importantly, Ashley challenged this by building on her own experiences of a woman of colour accessing healthcare, thus adding an important dimension to the impact power dynamics have within conscientious objection debates. Such experiences and opinions could fuel the assumption that healthcare professionals may object on racist and prejudice grounds and that conscientious objection should therefore be disallowed (Schuklenk, 2015). However, Cowley (2016) challenges this assumption as missing the point of conscientious objection, and that objecting on these grounds is never acceptable.

Multiple Roles

Several participants described their own job role and explained that they had worked within healthcare and accessed an abortion; therefore, they assumed dual roles of service users and non-objecting healthcare professionals or multiple roles of objector, non-objector, and service user. For instance, Jane and Holly were both practising midwives; Dani and Nadia were student nurses; Nadia had previously studied one year of midwifery. Holly was the only participant working in healthcare who had objected, and she commented that she sometimes thought to herself "yes but you were on both sides of the coin, you were a patient once, and you were, a care provider, and I have been an objector. I've been all three. It's impossible isn't it really". Holly explained that due to her different identities, it is challenging for her to form an overarching opinion of conscientious objection, as she believed that healthcare professionals should be able to object, but they also have a duty to provide care.

Moreover, all of those working in healthcare positions described the importance and duty of providing service users with care. Holly and Nadia commented on the importance of providing care even if it contravenes your beliefs and values, as stated by Nadia: "as a student nurse, I also think about likeee, we're there to provide, a service and we've come into this profession to help people, and, we might not necessarily think… Er like agree with things. Like, where would it stop? Like, say if someone comes in and, they're like a drug abuser, and, they, you know for a fact they are still abusing drugs. But obviously it's, it's their choice, […] would you choose not to… care for them?" It was evident that those with multiple roles reflected on the importance of providing equitable, non-discriminatory care for all. This resonates with the findings of Karabulut et al. (2022) who found that nurses considered not discriminating between service users to be a fundamental value of nursing. Conscientious objection was therefore understood as a potential form of discrimination where service users would be treated differently. This was deemed unacceptable as participants with multiple roles believed that healthcare professionals must remain objective and not express or act on conscience claims, at their own expense, as part of the job. This is a common argument presented by proponents of the incompatibility thesis (Wicclair, 2011).

Moreover, Holly acted on the opinion that service users should come first, as she went from objecting to no longer objecting because of the importance of the service. However, she saw this as a personal choice because she still understood the moral dilemmas of working in healthcare, and that healthcare professionals should have the right to object, commenting that "I would defend to the death, their right to [… object]. But I still believe in the service. That's why I. Personally. Still don't object to most things. Anything". Thus, Holly had opinions that reflected the middle-ground approach and healthcare professionals' right to object, though her actions were in line with the incompatibility thesis (Wicclair, 2011). Holly's actions implied that care of service users is more important than the rights of healthcare professionals. This could reflect one of the ways in which women are socialised to put others first and care for them. This serves as the foundation for the sexual division of emotional labour and can be used to explain why more women assume nursing and midwifery positions than men (Gray, 2010).

Moreover, participants with multiple roles often focused on their own professional role, and presented arguments endorsed by the incompatibility thesis (Wicclair, 2011) which fit within feminist constructions of women as caregivers (Gray, 2010). However, they all considered the importance of respecting healthcare professionals' rights to object. This highlights the complex philosophical nature of conscientious objection.

Cultural Context

The legal context around abortion in the UK was seen as important to participants, as they viewed abortion as an important, safe, and essential part of healthcare that is not up for discussion. When participants voiced this opinion, abortion was presented as a universal right and not as a binary of undeserving and deserving service users. Thus, participants felt that conscientious objection should not impinge on this, as exemplified by Jess's commentary: "we've already been through all this. We've allowed abortion in this country… That's what we're doing. I'm sure if abortions, hundreds of thousands of abortion started killing women all over the country because of something going wrong. Then yeah, we'd stop it immediately". Participants also felt that abortion will and always should be available in the UK. Dani commented that "there will always be services for it. I mean. Like well - touch wood - like there will always be services for it in this country". This reflects the perceived liberal feminist rights-based stance the UK takes on abortion and that participants viewed conscientious objection as problematic regarding service users accessing abortion.

The cultural context was also seen as important as participants who experienced mistreatment from their healthcare professional were angered by the way in which they were treated given the perceived legal status of abortion in the UK and the influence of feminism, and the advancements it has brought. Jess commented, "I was made to suffer that day, in a country where abortion is legal". She focused on the negative emotional impact of her treatment by her GP when he refused even to have a conversation with her about abortion and who she could turn to. Jess' case exemplified the removal of service users' voices, autonomy, and power, as she was left hopeless and had to navigate abortion without her GP.

Also, within the context of the UK, the NHS was seen as extremely important in relation to conscientious objection, as it is funded by the taxpayer, should reflect the views of the majority of society, and its services should be accessible to all. Emma commented "[t]hat's giving access to a service that is available through the NHS, it is part of your job". This supports the argument that healthcare professionals are actors of the state who are given knowledge and power in exchange for providing all services (Rhodes, 2006). It was also implied that the NHS is a service that promotes equality and autonomy for all.

By contrast, institutional conscientious objection was seen by some participants as acceptable in other countries due to different mainstream religions and cultures. For instance, Janie stated, “so what I understand of these countries is that they don't allow such a thing, so we shouldn’t judge them wrongly because it’s their religious ways”. Elise provided an example of this: “I would expect that [(conscientious objection)] from Italy because it's a Catholic country”. However, participants did not associate conscientious objection with the UK, despite it being a state governed by religion, as Lauren commented “I knew there was like people in the states. Who would definitely object. There are issues, obviously in Ireland as well with religion, but yeah, I hadn't realised it was maybe as much as an issue in the UK”. Thus, some countries were othered and viewed as less progressive regarding women’s rights, feminist thought, and abortion than the UK. They were seen as less liberal and tolerant and participants believed that the law in such areas is influenced by religion, which has been presented as inherently patriarchal by radical feminists (Stopler, 2005).

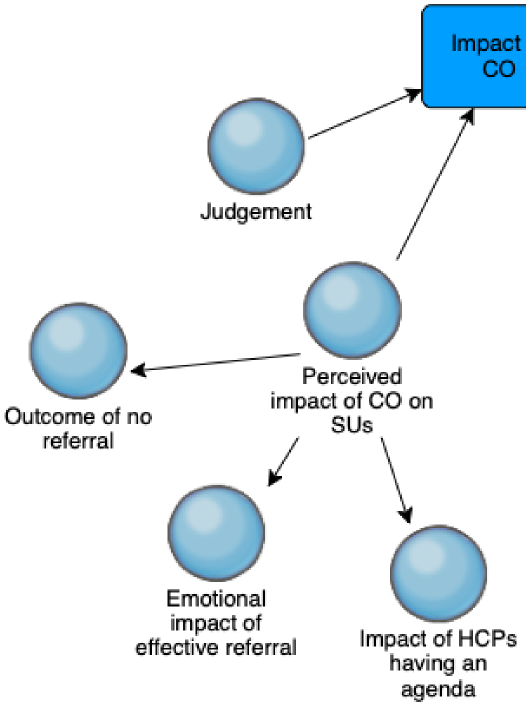
Therefore, the context of the UK and the influence of feminism was seen as important when assessing one’s opinion on conscientious objection as the NHS, religion, the right to abortion, and mainstream norms and values all played a part in whether participants believed that healthcare professionals should be able to object.

Conscientious Objection as a Numbers Game

Participants often presented conscientious objection as a numbers game, deeming it acceptable in situations where service users could access abortion elsewhere. For this reason, it was seen as acceptable in the UK, as many participants argued that there is always someone else to fill the role of the objecting healthcare professional. For instance, Katie commented that “[y]eah, I think their religion and their beliefs should be respected, because I'm sure there will be someone else who's willing to participate, and also to supervise”. Participants also believed that service users can access abortion care elsewhere – as there are numerous providers in the UK – should they encounter an objecting healthcare professional. For instance, Charlie said that “I think, we're in the UK, like we're in a position where, we can withhold, we can have, we can hold people who, object because there's enough options there for women, to find alternatives". Charlie's comments placed the onus on the service user to find a willing healthcare professional, although she believed this would not be problematic in the context of the UK. This approach is endorsed by Cowley (2017). Again, debates around institutional conscientious objection were presented as a numbers game, as several participants claimed that institutional conscientious objection would be acceptable if there were enough abortion providers available. Pam, for example, commented that "if it can't be the religious hospitals that can't offer it for their own reasons, fine. As long as somewhere is found where they can do it. So in other words, all parties are happy". This indicates that access for service users is afforded higher priority than an institution's right to object, but if there are other abortion providers available then institutions should be able to object. This reflects an outcome-based approach that balances the rights of service users and healthcare professionals, in the same way as suggested by Wicclair, (2019), such an approach could be supported by the liberal feminist tradition.

The Impact of Conscientious Objection

Figure 7: Theme three: the impact of conscientious objection.



Judgement

Participants viewed judgement on multiple levels. Firstly, some proffered that conscientious objection is inherently judgemental towards service users. Diana stated that healthcare professionals who object are essentially putting the following message across: “I don't agree with it. I'm judging you. I object to this procedure”. This supports the incompatibility thesis approach (Wicclair, 2011), and claims made by Fiala and Arthur (2014), Shahvisi (2018), and (Shaw, 2018) and assumes that healthcare professionals are in a position of power over service users as they are able to cast a meaningful judgement which could have repercussions (Shahvisi, 2018).

Moreover, participants explained that even the act of referring service users could be seen as judgemental; for instance, Lauren stated that “I suppose the thing, just go back, to kind of somebody who objects, that they're happy- or not happy to refer - but they will refer you. I mean…I suppose there's also like a bit of an element that you know. They'd be making clear that they disapproved of what you were doing. They disapproved of your choices and. […] [T]hat wouldn’t be helpful… you don't need somebody else, erm, piling on some more disapproval”. Judgement in this sense was seen as problematic as participants believed that health services should provide equitable treatment for all, without the emotional burdens judgement could place on participants, thereby adopting a rights-based perspective. Rosanna exemplified this when she explained the impact that conscientious objection could have on service users: “it could definitely make them question whether that is what they want, and I can probably almost guarantee that every person that’s in that waiting room has already been through that battle a million times in their own head… It definitely would have affected me, and I would've thought, well, I'm like, am I doing the right thing here”. Rosanna justified her position as she believed the decision to abort is a difficult choice to make and that the comments and actions of healthcare professionals could, but should not, influence service users’ outcomes. This supports a radical feminist incompatibility thesis (Wicclair, 2011) position.

Also, case-by-case objections were presented as problematic and unfair, as participants understood this as passing judgement and cherry picking. For example, Emma stated that "I think it should be equal for everybody. So if you if you disagree with abortion then, just treat everyone the same. As per your beliefs, if if you want to do that, but don't, just select people and say you can do that, but you should do that, like don't". Emma favoured blanket conscientious objection as she perceived it to be more fair and less judgemental, a stance which perhaps implies that some healthcare professionals may be acting on prejudice rather than conscientious objection. This argument is presented by some of those who support the incompatibility thesis (Wicclair, 2011) and radical feminism.

Nevertheless, the liberal feminist opinion that conscientious objection is not inherently judgemental was also discussed, as participants argued that different cases and circumstances could affect the conscience of healthcare professionals in diverse ways. Sarah exemplified this by stating, "[i]f I was, uh, you know, [a] healthcare practitioner. I think I would always look at individual circumstances. I think you have to, because everybody's circumstances are different, aren't they? … […]. I think if someone's too far along in her pregnancy. I might be more morally likely to, object 'cause for me I think you have enough time and we do have enough. You know services". Sarah focused on gestation and the moral impact this may have on healthcare professionals in placing a certain amount of blame on service users who access abortion later. This creates a dichotomy of deserving and undeserving service users, suggesting there is a window of time where service users should seek an abortion and anything past that time is morally questionable, thus highlighting the need for conscientious objection.

Conversely, institutional conscientious objection was perceived as problematic regarding judgement, as it was believed that allowing institutional conscientious objection plays into religious anti-abortion ideology and supports the control of women's bodies. For example, Rosanna argued that "[i]t's still putting, like the barriers out there that what. Women are doing is wrong, and that's not fair, it puts out that message still out in society for people to object to abortions and say that well obviously the Catholic, religion says I was wrong, so it must be wrong". Thus, Rosanna believed that allowing institutional conscientious objection sends a message to society and those accessing abortion that abortion is wrong. Supporting this rhetoric could be problematic as it could impact service users' moral stance and perceptions of abortion and increase the societal stigma of abortion more generally. This is a fear that could be recognised by radical feminists.

However, not all participants believed that institutional conscientious objection is a form of judgement. Instead, they understood institutional conscientious objection as a way of protecting healthcare professionals' religious freedom by creating an institution which supports their ethos and world view. Lauren, for example, opined that "I think that it's probably easier to get your head around in that, if it's, erm affiliated with a religion. I can understand that a bit more. And that would be part of their whole kind of ethos, and their setup, and the way […] in which they practice, would be founded following particular beliefs or values, so I think I could probably understand that more". Moreover, conscientious objection of this kind was seen as understandable, supporting Cowley's (2017) stance that healthcare professionals should work in an environment that holds the same values as they do because they may feel morally complicit by freeing up the time of other healthcare professionals who provide abortion care.

Perceived Impact of Conscientious Objection on Service Users

One of the main arguments for the incompatibility thesis (Wicclair, 2011) taken by radical proponents is that conscientious objection should not be permitted due to the negative impact it has on service users. This stems from the unequal power dynamic between healthcare professionals, healthcare institutions, and service users (Shahvisi, 2018). Ashley made it evident that she believed conscientious objection is problematic and acts as a barrier to access, commenting that "you put a number of obstacles in the way, suddenly something becomes a lot more complex than it originally is". However, others saw service users' individual autonomy as stronger than any impact conscientious objection could have. Holly commented that if a healthcare professional objected, she would "just go somewhere else. I'd probably be a bit bolshy". She implied that healthcare professionals do not have power over service users' decision-making, thus conscientious objection does not necessarily have to be a barrier. Jane elaborated on this, arguing that service users have power and autonomy due to technology as they can find out how to obtain an abortion online. This reflects the perceived ease of obtaining an abortion in Britain (Cowley, 2017).

Impact of Healthcare Professionals Having an Agenda

It was argued that some healthcare professionals who object would try to persuade service users not to go through with an abortion as they have an alternative agenda and would abuse their position of power. This is unacceptable when employing the middle-ground perspective (Wicclair, 2011). For instance, Harshil commented that "[n]o one can indulge and create uh, uh, a new opinion that what I expect them to do is to understand and respect the decision that we took, rather than trying to you know, come in our way and er, changing it upside down with their opinions". Harshil envisioned conscientious objection as a deliberate obstacle put in place by healthcare professionals, and an abuse of power. Katie's experience supports this opinion, as the doctor in the hospital she attended attempted to convince her not to go through with an abortion using medical misinformation and moral arguments – yet she did receive a referral from this healthcare professional. However, I cannot assume that all healthcare professionals who object attempt to prevent service users from accessing abortion, as Charlie had a much smoother abortion journey. The healthcare professional in this case informed her of her right to an abortion and referred her to a GP at the same surgery without attempting to deter her from accessing an abortion.

Moreover, several participants believed that if healthcare professionals do have an agenda to change service users' minds, this would result in someone following through with the pregnancy. Rosanna commented that "maybe they [(service users] were hanging on a thread, and to be told. Like, for someone to say, 'don't do this', and when someone objects like that, it can then completely change that person's life. 'cause they can go ahead and have a baby". Participants who held this stance implied that there is an unequal power dynamic between healthcare professionals and service users, whereby service users strongly consider the opinions of such professionals, as argued by Shahvisi (2018). This was indeed the case in Keeva's situation because the healthcare professional persuaded her not to go through with her abortion and signposted her to a counselling service. Notably, this interaction occurred in 2019 in NI. I cannot extrapolate this to the current climate in NI, due to the legal and social factors at this time.

Emotional Impact of Effective Referral

The participants commented that a healthcare professional objecting would have emotional and moral repercussions, even with a direct (effective) referral, thus supporting the incompatibility thesis (Wicclair, 2011) and radical feminism. Nadia commented that "I feel like if someone had turned around, and had been like 'Oh, I don't want to be a part of this'. I'd feel I was doing something wrong. And it would affect my mental health". Similarly, Aisha stated that if a healthcare professional wanted to object, she would "feel upset and unsupported. It's your first point of contact". Some participants believed that without an objective value-free health service, they would feel that their own decisions and morals were being questioned and that they were not being supported in accessing a safe and accepted service in the UK.

However, not all participants felt that a healthcare professional objecting would impact them negatively, provided they received a direct referral. Pam exemplified this by stating "as long as they [(objecting health care professional)] would refer me on to somebody else. Then fine, I'd get over it". The participants who took this stance showed tolerance and understanding towards those with objections and supported the middle-ground (Wicclair, 2011) liberal feminist approach. Charlie's experience supported this approach as she commented after her direct referral that "I didn't feel like erm… I didn't feel angry at her or… Or mistreated by her. I I didn't feel ignored by her, I just, I felt like it was handled in the right way". Thus, Charlie did not experience any negative outcomes due to her GP objecting.

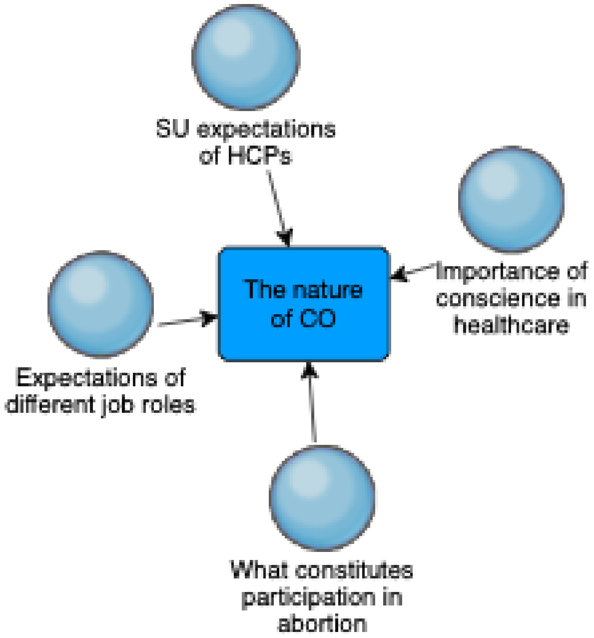
Outcome of No Referral

Participants stated that without a referral they would have been left not knowing what to do, which could have serious implications regarding timing and affect what type of abortion service users could access. This highlighted the extent to which service users are reliant on healthcare professionals and indicates that more public information is needed on how to access abortion. Katie commented that without a direct referral she "would have been stranded. Ok, I had no other idea of where to consult. Also confiding in someone and telling someone I really want this is not an easy thing". She also emphasised how difficult it was for her to approach a healthcare professional in the first place and disclose to them that she needed an abortion. The additional stigma of abortion and the cultural pressures Katie may have experienced would also have played a part in why she struggled to discuss her abortion needs.

Furthermore, Charlie explained that she would not know how to access an abortion if it was not through her GP. She commented that "I wouldn't even know to be honest with you, I think I […]. might have left that GP practice, and gone to a new one. But then that takes, can take a number of weeks. It adds more stress and more time". This highlights the important role GPs play in facilitating access to abortion and the lack of choices those accessing abortion felt they had. It intensifies the power dynamic and reliance on healthcare professionals between themselves and service users, as GPs may be seen as the only option and route to abortion care. Dani's comment also reflected this opinion as she stated that "if I did know about them [abortion advisory services], obviously I would, I would… Not in this horrible like, but I would basically tell the GP to shove it up their arse I'm going elsewhere". Thus, knowledge of abortion services played a huge factor in how participants reacted to a lack of referral or believed they would react.

The Nature of Conscientious Objection

Figure 8: Theme four: the nature of conscientious objection



Importance of Conscience in Healthcare

Participants believed that as a society we should aim to preserve conscience in healthcare. It was felt that the UK is a tolerant liberal society that should allow diversity in medicine. Ashley supported this approach, stating that if there were no objectors "you're gonna probably see quite a bit dilution of like diversity medical profession, which it probably isn't a good idea". She did not go on to explain why this would not be a good idea. This argument has been presented by Wicclair (2011) and Baker (2009) who comment that we should aim for pluralism and cultural and moral diversity in the health service, as these are principles of democratic, post-industrial societies. This can be supported by the liberal feminist tradition.

Also, participants commented that it is in the service user's best interest to be seen by a healthcare professional who is not forced into providing abortion care when they do not wish to. Amy stated that "if you are going to impose it [carrying out abortion] onto somebody,[…] how effective will they be in their role, if they feel they are doing something that is against their conscience". She believed that if healthcare professionals are forced into providing abortion when they have a conscientious objection, they will not provide adequate care. Jane elaborated further upon this idea: "I think women need to be treated with compassion, for what they're going through, and I think people should be able to object, to doing the process. And caring for people if they believe it's really wrong, because. I I think a woman who's undergoing a really traumatic experience, needs to have somebody there who doesn't judge her, and wants to help her". Amy and Jane believed that service users should receive care from individuals who want to provide abortion care and feel comfortable doing so, not for the sake of the healthcare professional, but so that the service user receives equitable, non-judgemental care. Moreover, Pellegrino (2002) acknowledges that if objectors are forced into providing abortion care, they may not be in the right frame of mind to provide adequate equitable care and advice to service users. Such an approach opposes the incompatibility thesis (Wicclair, 2011) and has been voiced by British midwives (Maxwell et al., 2022).

Similarly, Holly offered the perspective that as a service user she would feel guilty if the conscience of a healthcare professional was negatively impacted after being involved in her abortion. She stated "if someone didn't want to take part in that [her abortion], I would have bore that [guilt] on my shoulders. I wouldn't have expected them to bare it on theirs. And I wouldn't want anyone to feel bad about helping me". This depicts a selfless perspective, whereby service users may wish to protect healthcare professionals, as they understand the impact that their need for care could have on them.

Service Users' Expectations of Healthcare Professionals

I uncovered several opinions in relation to the duties of healthcare professionals. Firstly, it was argued that they have a duty to fulfil all aspects of their job role, pre-empt any objections they may have, and work in another area of healthcare if they cannot provide abortion services. This is one of the main tenets of the incompatibility thesis (Wicclair, 2011) and would be supported by radical feminists. Also, participants believed that healthcare professionals should have certain qualities when working in healthcare, and they compared these qualities with their own job or other jobs to reiterate this. On the other hand, it was argued that referring service users is sufficient for professionals to fulfil their duties, an argument presented by those supporting the middle-ground approach (Wicclair, 2011).

Participants who endorsed the incompatibility thesis (Wicclair, 2011) and radical feminist position spoke about the duties of healthcare professionals and that they should fulfil their job role, in an angry tone and it was obvious that they felt very passionately about service users' right to access abortion. Dani commented that "you [(health care professionals)] know what your role entails, and so even if you don't agree with something, that's part of your job". Participants also drew upon the fact that healthcare professionals have signed a contractual agreement and that this should be honoured. For instance, Pam stated that "[y]ou go into a job, at that point you are agreeing to a contract, you're accepting to agreeing to, be willing to carry out any task that is required of that role". This opinion is presented by Rhodes (2006). Participants acknowledged that a high degree of self-governance and a monopoly of knowledge and service provision is provided by society to healthcare professionals and that they should respect this by offering all the legal services they are trained to provide. Pam went on to develop her opinion as follows: "[m]aybe the logical approach would be to raise it in the very beginning anyway. The start of […] even going into, *practitioning* in the first place. Even considering it as a job". This opinion was reiterated by other participants as they believed that those unwilling to provide abortion services should not be in this area of healthcare or should work in another profession. For instance, Jess argued "I just think that, if you don't want to do that, there are other parts of health care, that you could do. There's so much. You know you can work with children with disabilities, you can work in the mental health part". These opinions reflect the standpoint that healthcare professionals should not enter healthcare if they are not willing to provide all legal services (Savulescu, 2006; Schuklenk, 2016; Schuklenk, 2018), which is consistent with the incapability thesis (Wicclair, 2011).

Moreover, participants expected healthcare professionals to possess qualities that allow them to remain objective and leave their personal opinions to one side. Lauren explained that "[w]ith something like healthcare, erm, it's got to be quite detached and unemotional, isn't it? Erm… You know. Healthcare professionals are… They train and they're making decisions…Based on their expertise and for. The treatments that their patients need, so. Whilst it might be hard for… for them sometimes to go home after a harrowing day. And you can't. You probably can't help but take some of that home with you. They're still doing their job, and that's what they've trained to do". Lauren saw conscience and emotions as barriers to effective healthcare, unlike Wicclair (2011) who makes the case for preserving conscience in healthcare. Lauren argued that it is important for those in healthcare to remain objective, so their own personal opinions do not impact on the care service users receive.

Conversely, some participants felt that healthcare professionals should not be objective and should be compassionate towards service users accessing abortion. For instance, Jane commented that "I think women need to be treated with compassion, for what they're going through". She presented abortion as different from other types of healthcare and implied that it can be an emotional and painful experience. The need for understanding and compassionate healthcare professionals was seen as an essential trait and duty. Jane believed that conscientious objection should be allowed to ensure that all healthcare professionals act compassionately towards service users and are not there simply because they are unable to object. This opposes the incompatibility approach, but supports Pellegrino's (2002) stance that healthcare professionals should provide empathetic care.

Moreover, participants compared the roles of healthcare professionals with other job roles and their own, which indicated the expectations they had of healthcare professionals. Diana compared healthcare professionals who encounter abortion with her own job role as a counsellor, commenting "I think that if you're going into a certain. A certain area. Whether it's medicine or like myself counselling, I can't say, […] I don't want to take you. If people come through our charity. I can't say I don't want to take you because I don't agree with your lifestyle, or I don't agree with this, or that". Diana argued that healthcare professionals and counsellors should provide equitable care for all and should not refuse to accept clients because of their own beliefs. This supports the incompatibility thesis (Wicclair, 2011). Diana expected healthcare professionals to be able to push their own beliefs to one side to provide care for service users, as she does in her position as a counsellor.

On the other hand, not all participants held expectations that healthcare professionals should take on all service users. For example, Holly understood the ethical challenges within healthcare because of her own role and experiences of being a midwife. She commented that "healthcare professional are only human". She then went on to say "I've never ever, come across a midwife, or a doctor, or a healthcare professional, who has never had any conscientious dilemma". She indicated that the incompatibility thesis (Wicclair, 2011) expectation that healthcare professionals should or can remain objective and leave their beliefs outside is unrealistic and that healthcare is fraught with ethical dilemmas. Therefore, healthcare professionals should be able to act on ethical dilemmas to preserve their conscience; it is unreasonable to expect too much of them as they are only human. This reiterates the core question – can healthcare professionals remain objective and leave their beliefs outside of healthcare? – which has been raised within the academic literature (Wicclair, 2011).

For others, referral was seen as an acceptable duty and a compromise for conscientious objection, as it is in the liberal feminist and middle-ground approach (Wicclair, 2011). Pam stated "as long as they direct them to someone who can. So at the end of the day, the patient still ultimately gets that service then that's really what needs to happen". This indicates how the outcome of the patient is prioritised, whilst considering healthcare professionals' beliefs and ethical dilemmas. Tia used her own job role as an example to show that referring service users should be acceptable. She commented that "[i]f there was something I came across, say in mental health. You know, there's a lot of sensitive topics.

If I wasn't comfortable with that, and I've got colleagues, you know that just referred on. Because they're not comfortable dealing with that particular topic. So I think we're all human". This opinion was the opposite to what Diana felt was acceptable in her job role as a counsellor, as she felt that one should work with the patient regardless of one's own beliefs. Tia took the same approach as Holly as both commented that healthcare professionals are only human, meaning they should be able to object to preserve their conscience and protect themselves.

Expectations of Different Job Roles

The participants' opinions of conscientious objection differed depending on the role of the healthcare professional we discussed, as their expectations of what the job should involve varied. Four main perspectives were presented: midwives should not be able to conscientiously object, GPs should not be able to conscientiously object, GPs should be able to conscientiously object as abortion is not part of their job role, and midwives should be able to conscientiously object as abortion is not part of their job role. Sarah expressed the first opinion that midwives should not object as she stated, "I think, especially with midwives. Again, it's sort of hand in hand with women, you know, gynaecology and what have you? It is the same sort of service isn't it? erm Women's Health erm. I mean, I think if you go into that job you kind of know you're gonna come across it probably at some point erm. You're informed really aren't you". It was evident that Sarah saw midwifery as women-centred care and that abortion falls into this category and she believed that midwives enter the role informed about this and so they should not be able to object. This stance is evident in the incompatibility thesis (Wicclair, 2011), as it is believed that healthcare professionals have the power to decide if they want to be involved before they enter the health service (Munthe, 2017).

However, not all participants believed that midwives have a duty to provide abortion care. Lauren commented that "obviously if you've trained to be a midwife, then the training that you've undertaken is to deliver babies. And if you are then. Erm put in a position where you're not delivering babies, but you're preventing people having babies, that I can understand erm. Conscious conscientious objection in that, because I mean, you know people trained specifically to be midwives. Erm, so I can. I can kinda get my head around that". She drew on the association of midwifery with childbirth and that midwives may enter the profession because of humanitarian and potentially religious concerns surrounding the sanctity of life and to alleviate suffering. She presented abortion as the opposite of this and believed this is outside the scope of what being a midwife entails. Thus, not all participants were aware of the changing role in midwifery whereby midwives come into closer contact with abortion (Ramsayer & Fleming, 2020).

Polarised arguments were also presented regarding GPs. Lauren commented that abortion is integral to a GP's role: "it's got to be something they would expect, erm, and obviously there's people coming in with all different kinds of things. There are general practitioners, but, you know. Uhm, kind of sexual health and uhm. You know family planning, and that is part of their, a major part of their role as well". She believed that a GP's role should include abortion and that this should not been seen as an alternative part of healthcare. She believed that if abortion care was seen as separate, it could be stigmatised. Moreover, participants' reflections on not knowing how to access abortion without a GP supported this perspective, highlighting the importance of GP involvement in abortion care. Findings from other research also indicate that in England, GPs play a crucial role in facilitating service users' abortions and educating service users on how to access abortion (Finnie et al., 2006).

However, a less prevalent opinion was that a GP's role should not include abortion. Elise made this clear by commenting that "[i]t opens up another realm, it it changes what GP is. GPs, people always go there, you're sick, you've got a flu, you get an injection, you're going on holiday, they weigh you, take your temperature. All of the above. but never have I associated GP with abortion". Elise built this opinion on her personal prior association of what a GP 'should' be and what type of care they should provide. She believed that abortion access should be sought through sexual health channels. Her own abortion experience reflected this preconception.

What Constitutes Participating in Abortion?

Fleming et al. (2019) argue that it is important to have a working definition of what constitutes participating in abortion. It was essential to elicit service users' perspectives on this as they have a unique standpoint as receivers of care; hence, their opinions may differ from those of healthcare professionals (Maxwell et al., 2022). Moreover, asking this question creates a more complete picture of what participation in abortion entails.

Participants opinions on what constitutes participation in abortion varied considerably, as I depict in Figure 9. This resonates with the opinions of British midwives, which were also varied and complex (Maxwell et al., 2022).

Firstly, some participants took an extreme approach, as reflected in Jess' comment that "[e]very single one of us [participates in abortion], we pay taxes. We do, anything we do, we are participating. So even those 100% against it, they don't realize they just participated in it". This argument is discussed within the literature (Rahn, 2021). Jess also commented that "working for the NHS is participating in abortion. You're part of the NHS, you're you know, or if you work for a company that provides funding, or provides a medication. It's all participation". It was evident that Jess drew on an extremely wide definition of participation, claiming that anyone who funds the NHS through their taxes or works for the NHS is participating in abortion. Some conscience absolutists take the approach that those who work in an institution which allows abortion are participating in abortion by freeing up the time of healthcare professionals who are willing to provide abortion care, thereby supporting institutional conscientious objection (Cowley, 2017). However, this stance could also be used to support the incompatibility thesis (Wicclair, 2011) to prevent those with objections working in healthcare, which reflects Jess's stance more accurately.

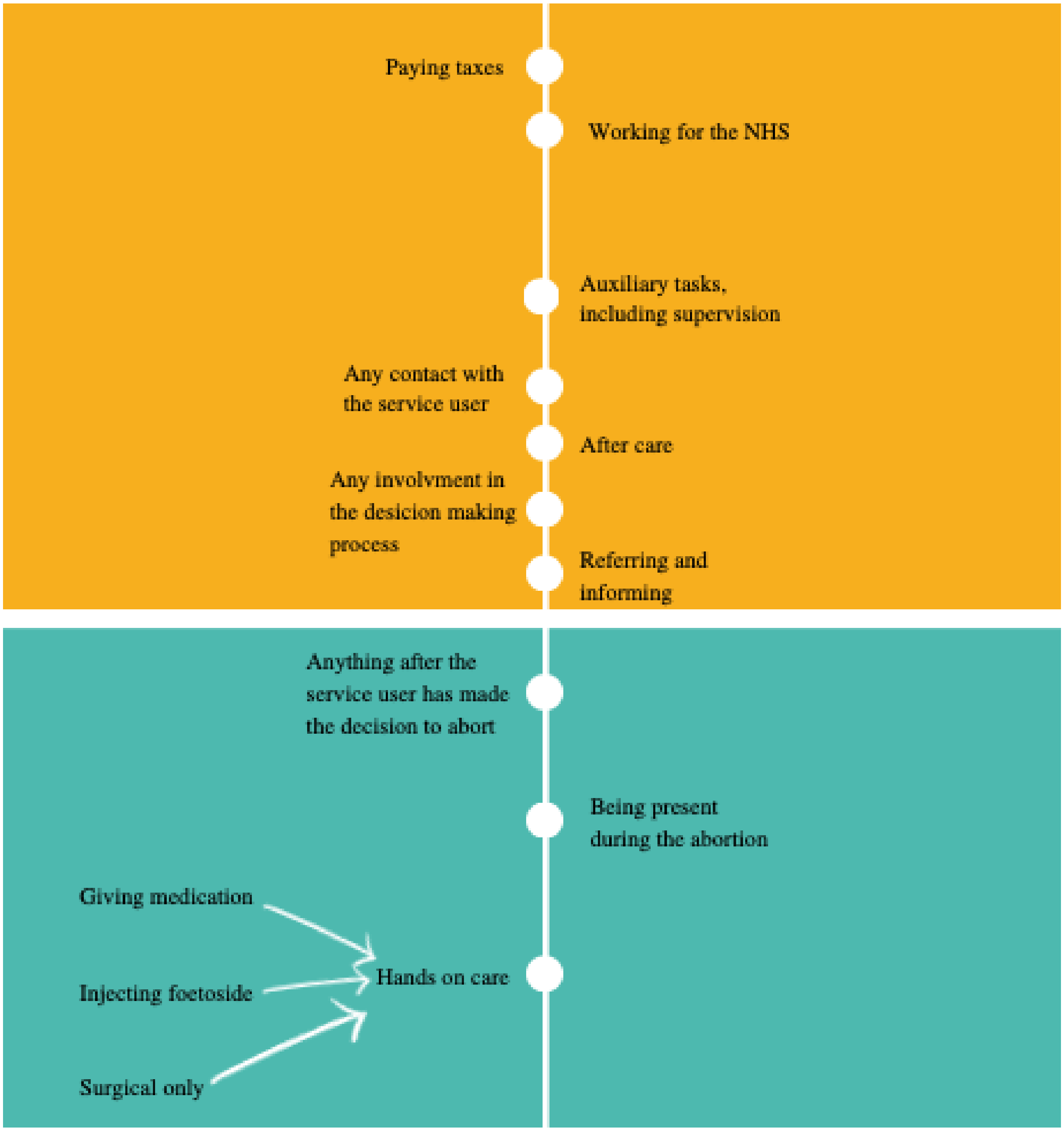
Moreover, some participants commented that healthcare professionals who perform auxiliary tasks, including supervising professionals who are providing abortion care, are participating in abortion. Pam made the following comment in relation to auxiliary care: "you're not doing it, but you're still making it happen, even by the the backup side of things is you are part of the process”. Again, this is an argument proffered by those who support conscience absolutism (Wicclair, 2011) and the beliefs held by Doogan and Wood as they claimed that they should not have to supervise those performing abortions, as this should be considered participating (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014).

Jane further commented that any part of the abortion process could be seen as participating in an abortion: “I suppose it's like any part of the process, and some people may object to looking after the woman in the post, operative stage, or during, you know, the actual process”. Although Jane elaborated upon this slightly, she remained rather vague in her description of what ‘the process’ is. This exemplifies the current issues around defining what participating in abortion means. Similarly, some of the British midwives interviewed in a recent study defined participation as “everything” (Maxwell et al., 2022, p. 4), as they believed that midwives should be ‘with woman’ throughout the entire process. Thus, it is evident that Jane and some of the midwives in Maxwell et al.'s (2022) study adopted a wide definition with regard to what constitutes participating in an abortion.

Diana gave a more in-depth account, commenting that participating denotes any involvement with the service user, as she stated that “participating is any kind of contact…with the woman who's accessing it. As far as I'm concerned”. Thus, according to Diana, healthcare professionals who give care before and after the abortion, who encounter the service user and those who refer or inform service users (if they have an objection) are participating in the abortion.

Similarly, Nadia believed participation refers to anything that occurs after the service user has made the decision to abort, stating, “some people would think it’s from the moment that person has made that decision, all the way through to the aftercare”. Notably, Nadia did not claim that this was her own opinion, but that “some people” may believe this. It is likely that Nadia removed herself from this opinion as her previous responses fit within the incompatibility thesis (Wicclair, 2011) approach, but she could understand why healthcare professionals may feel this way.

Figure 9: Participants' views on what constitutes participation in abortion.



Amy contended that healthcare professionals are or can be involved in the decision-making process and that this alone is participating in an abortion as she stated that "having anything to do with the decision process, that's participation, at any level". This meant that Amy viewed the act of deciding to have an abortion as an important aspect of the abortion journey and thus, participation. Notably, the majority of participants in my programme of research and in previous British research (Baron et al., 2015) had already made the decision to abort when approaching the healthcare professional, meaning that if Amy's definition were to be used, few healthcare professionals would be participating in abortion.

Also, some participants saw informing and referring participants as participating in an abortion; for example, Pam described participation as "being responsible for arranging it erm and uh and there onwards really, even discussing it. I suppose". This position represents the meaning of participation for conscience absolutists (Wicclair, 2011), as proponents believe that healthcare professionals should not have to refer and inform service users, as doing so makes them morally complicit and therefore, constitutes participation (Cavanaugh, 2010).

For Sarah, healthcare professionals' whereabouts are important as she claimed participation is "being present… in the theatre, or being present whilst somebody is having medication administered". Again, this was a wide definition as she did not specify that healthcare professionals must be providing hands-on care, simply being there is enough.

On the other hand, participants presented definitions supported by the middle-ground approach (Wicclair, 2011), as evidenced by Aisha's comment that participation is "just the giving of the medicine and the surgery". The majority of midwives in Maxwell et al.'s (2022) study viewed participation as giving the medication to induce labour. This reflects a narrow hands-on definition of participation, similar to the definition used in the Doogan and Wood case, as it was argued that this is what the 1967 Abortion Act means by participation (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014).

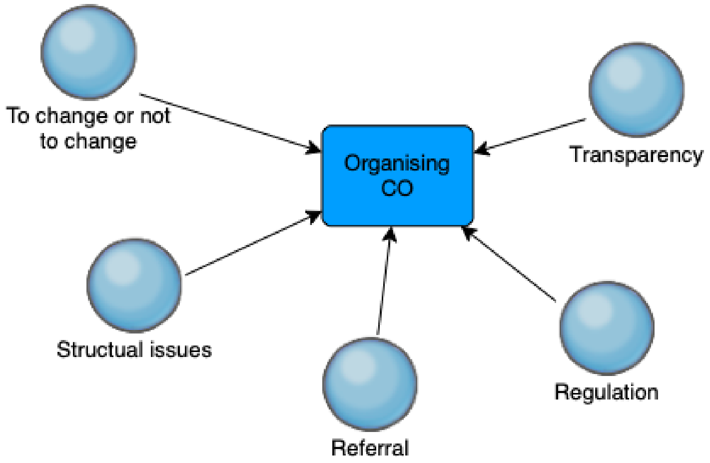
However, Emma went one step further by distinguishing between giving medicine and performing surgery: "I'm not sure howww someone is participating into your abortion, 'cause it is your abortion. They're only supplying you with, the medication. The only participation that you might have is maybe the surgical route, where you physically take the foetus out. Erm, I think that's classed as participation". Emma's definition drew on autonomy and choice as the service user chooses to take the aborticide after it has been administered by the healthcare professional. Emma therefore saw giving medicine as facilitating rather than participating in abortion. She made the distinction between this and physically removing a foetus in a surgical abortion. Emma's definition was even narrower than the hands-on definition that has previously been presented (Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 2014).

Holly's definition was also extremely narrow as she claimed that participation is "the actual demise of the foetus, like you know, the foeticide, injecting potassium. But not the delivery". Her definition focused on her own experience of abortion as a healthcare professional within midwifery, as she did not comment on medical abortion, but focused on the role of the midwife in abortion care.

Finally, it is important to note that there was a disconnect between what participants felt participation was and what they believed healthcare professionals should be able to object to, as most participants presented definitions that favoured conscience absolutism but took a middle-ground or incompatibility thesis approach (Wicclair, 2011). This has important ramifications in practice and with regard to law and policy. I elucidate participants' overall ethical positions in the section titled 'overview of participants' ethical perspectives.

Organising Conscientious Objection

Figure 9: Theme five: organising conscientious objection.



To Change or Not to Change

Participants presented arguments for both preserving the current system and upholding the status quo and for changing it. Those who believed the current system is acceptable often had not considered that conscientious objection could be problematic and a barrier to care for service users. For instance, Lauren said “it's not something that I've considered an issue before, and I think probably the way it is it in the moment, in this country, it's probably […] ok”. It is important to note that the context of the UK was seen as important when discussing whether change is needed, as Lauren assumed abortion is easily obtained and readily available, and that healthcare professionals’ treatment of service users does not need to be monitored. This could be attributable to the role of liberal feminism within the UK and law-making processes that present a seemingly gender equal society. Notably, none of the service users who experienced ineffective referral (that went against policy and guidelines) supported the current system.

Jess had strong opinions on conscientious objection as she commented that the system needs to change. Her own experience of a GP refusing to discuss abortion with her could have fuelled this, as she commented that “there definitely needs to be something to stop, doctors turning you away. […] I dread to think how many women have actually gone on and topped themselves because of that, or done something really, really stupid”. She adopted a radical feminist position and presented treatment that does not comply with policy and guidelines as an unacceptable, life-altering situation that could result in extreme consequences such as a service user taking their own life. It was evident that Jess saw the current system as ineffective, as not all service users receive information on how to access abortion or indirect or direct referral, meaning change is needed to protect service users. Participants also saw room for change regarding structural issues, regulation, transparency, and referral, as I explore in the following sections.

Structural Issues

Those who commented that the current system is not sufficient for dealing with conscientious objection offered insight on structural resolutions and argued that abortion should be a separate form of healthcare and that preventative measures should be taken to stop service users encountering healthcare professionals who object. For instance, Ashley commented that "there should be some sort of procedure in place already, whereby [… a] service user doesn't have to even confront a doctor who […] turns around and says no, I don't want to do this". It was evident that those who envisioned the need for structural change focused on preventing service users from encountering GPs. Jess also took this approach as she offered a practical solution: "I don't know, you know, a special number to call which sounds, but maybe it's all too much. But I just thought, so if I could have a special number I could've called, and said look, I I'm I'm calling this number, you know why". In Britian, MSI and BPAS can be seen as separate forms of healthcare with separate routes of access such as calling over the phone. Participants' comments indicated a lack of awareness around these resources and accessing abortion via self-referral.

Furthermore, Ashley made her lack of awareness around accessing abortion clear by stating, "I'm pretty clued up, and even I was like a bit baffled about who the hell you speak to". Sarah also did not know the details about accessing NHS care from private clinics, as reflected in the following conversation I had with her: "Becky: we've got BPAS we've got Marie Stopes. erm, yeah, that would be their argument. What do you think about that? Sarah: Aren't those clinics private clinics though?" Such beliefs left participants reliant on GPs or sexual health clinics. Moreover, lack of education was brought to the forefront of arguments around conscientious objection and the association with knowledge and power. Participants reflected upon this, suggesting that education is imperative alongside any changes, as Lauren stated that "having some transparency about the different routes that are open to people, that would seem to be. Necessary". Thus, education was seen as an important step to empower service users and provide them with the knowledge to self-refer to abortion advisory services, making it less likely that they would encounter a healthcare professional who has an objection.

Referral

Whether healthcare professionals should refer service users and if this is done directly or indirectly has been widely debated within the literature. Proponents of the middle-ground approach believe that direct referral is essential and that healthcare professionals should not be able to object without doing so (Brock, 2008; Wicclair, 2011). By contrast, conscience absolutists proffer that healthcare professionals should not have to refer (even indirectly) service users, as the act of doing so makes them morally complicit and this will impact their moral integrity which conscientious objection aims to protect (Fink et al., 2016; Minerva, 2017; Trigg, 2017). Participants voiced both opinions. The majority of participants took the middle-ground approach (Wicclair, 2011) as they believed that direct referral should be an essential part of conscientious objection. Katie commented that "I think if at all they are not able to carry out the abortion, it's good for them to refer someone. So they are sure someone will carry out the abortion, and that it's going to be safe and successful". It was evident that Katie had concerns with service users having the ability to access safe abortion or even access an abortion at all, as she reflected upon this concern in her own abortion journey when she described that the healthcare professional she approached objected. Thus, Katie believed it is of the upmost importance that healthcare professionals refer service users to enable them to access abortion, due principally to the unequal power dynamic between themselves and service users, and the uneven distribution of knowledge.

Charlie's experience supported the need to refer as she did not experience the same emotional turmoil as those who were not referred. Her views on referral reflected this as she commented that "she [(the GP)] didn't like close the door on me completely by saying 'nobody is going to help you' … I think that that cast the right amount of balance, because while she said she didn't […] want to take part in that, she didn't refuse any other alternatives […]. She offered me the other health professional. The second so it wasn't like she was completely closing the door on me". Charlie believed that healthcare professionals should refer service users, as not referring them would effectively be shutting them down and would imply that no one else would be willing to help. Charlie believed that this message is unacceptable, and that the healthcare professional has a duty to refer service users to a colleague, so they can access abortion effectively.

On the other hand, some participants believed that healthcare professionals should not have to directly refer. Amy took the conscience absolutist perspective, stating, “If I say, I do want to be referred, and I do want somebody else to give me their opinion on it. Or who will allow me to access the service. Then… I think they’ve waivered, they’ve waivered, they have ermm… they have conscientiously… erm done what they felt they didn’t want to do”. She believed that if a healthcare professional refers a service user, they are effectively a link in the chain and are morally complicit in the abortion. Therefore, to protect their conscience, such professionals should not have to refer and inform service users.

Transparency

Opinions differed regarding whether healthcare professionals should inform service users of their objection. Those who opined that they should explain their objection viewed it as important that service users had clarity and would understand that the healthcare professional’s objection is for a personal rather than a medical reason. For instance, Pam stated “[i]t would be good to be provided with some explanation. It doesn't, obviously […] have to go into detail. That's a personal business, but just some overview of why, why they couldn't. To help me understand better or educate me, you know?” Katie drew upon her own experience, commenting that “[y]eah, sure, it's a good reason for someone to take, like for me, the way the professional told me ‘I can't do this abortion because of this, this and this’. And ok, it felt kind of, ok it was good and bad 'cause I wanted to do it, but at least, I could see his reasoning, and his sense of why he's not doing it”. Katie and Pam both believed that it is important for the service user to understand why the healthcare professional is objecting. Pam explained that this need not be a detailed explanation, but simply enough for the service user to clearly understand. Current policy for doctors states that they should inform the service user of their objection without passing judgement and that they do not have to go into detail if they do not wish to (General Medical Council, 2020b). This stance has also been highlighted in the literature (Brock, 2008).

Conversely, some participants believed that disclosure should be at the discretion of healthcare professionals. Janie commented that "[i]f the doctor wishes to tell the client. The reason as why his conscientious can't allow him or her. It's ok. But I don't see it as ah it's necessary to tell the patient". This suggests that the process of disclosing one's objection is to benefit the healthcare professional rather than the service user, and they should only disclose this information if they feel comfortable doing so. This opinion fits current GMC guidelines which state: "You [(doctors)] may wish to mention the reason for your objection, but you must be careful not to imply judgement of the patient" (General Medical Council, 2020b, p. 12).

However, participants also felt that healthcare professionals should not discuss the reasoning behind their objection with service users. For instance, Emma asserted that "I think that they they could say they don't want to take part in it, but I don't think they should give you information about why they think that they, that I shouldn't do it. Because that's again, that's influencing the persons decision". This position relates back to the arguments presented around judgement as it was believed that service users may feel judged if healthcare professionals disclose their reasons for objection. This could impact a service user's decision to abort, and their own morality. This was seen as unacceptable within healthcare.

Regulation

Polarised beliefs were apparent in relation to regulation. Firstly, some participants felt that conscientious objection should not be regulated in the UK, while others felt that regulation is necessary. Lauren took the first of these stances and commented that "I'm not sure that additional regulation… would be helpful, either, uh, because I think you know you. You've got to kind of respect, each individual's wishes whether you know, it's a person seeking support, or it's the practitioner if they […] don't want to do it, then that's ok".

Lauren felt that regulating conscientious objection is unnecessary, as she believed that those who wish to object should be able to do so without being questioned and that regulation could impinge on this right. Participants also had concerns with regulating and questioning why a healthcare professional wishes to object in a tribunal setting. Participants saw this as an exercise that would remove the rights of some and not others and as a bureaucratic hoop-jumping exercise with no real value, as no one has the authority to judge another person's morality. Holly took this view, as she stated, "[t]hat implies that one person has a power over someone else. Whereas in terms of rights, and ethical standpoints, they don't. There is a hierarchy in the health service, a banded system, that sometimes I've become a cropper, really. Because someone is senior doesn't mean they are more right". Holly suggested that there would be power issues at play, and that those who are able to judge others' rights would only have this authority through power rather than experience. She built upon her own personal experience within the NHS when she legitimised her reasons for this opinion. Those who are anti-regulation present arguments claiming tribunals are fraught with issues around validity, genuineness, and reasonability, similar to the opinions of Cowley (2016a) and Marsh (2014).

Conversely, some participants felt that it was imperative to regulate conscientious objection to protect service users. Katie believed that it is important to assess why healthcare professionals object to prevent false claims, stating, "I think, they should give a reason as to why they are objecting. And alsooo, they should not just give any reason. The reason should be valid, right for example, like their religious beliefs. It's something most of us believe at all, maybe Christianity beliefs, some of us know them, and so you will feel that, ok it's a good reason he's giving". Katie argued that it is possible to assess the validity of a healthcare professional's objection and that doing so would not be a pointless exercise, rather it would help to protect service users. Such approaches are proposed by several academics, as Meyers and Woods (2007) state that objections should be assessed in terms of genuineness and reasonableness, as well as Card (2016) who focuses on reasonableness. Participants also believed that regulating conscientious objection would be helpful from an organisational perspective as the number of objectors would be known, which could help reveal whether there are enough healthcare professionals willing to provide abortion care. Amy contended that regulating would be a "good way of, almost measuring within the medical profession. Hmmmmm. People, yeah people that, don't want to do it. As opposed to people that are happy to go ahead and do it". She also implied that regulation could aid healthcare professionals in expressing their objections and provide an environment where conscientious objection could be openly discussed, meaning their rights would be respected and known. Thus, it is evident that there was no clear consensus among participants whether conscientious objection should be regulated.

Overview of Participants' Ethical Perspectives

Participants' opinions of conscientious objection varied considerably, as aspects of all three approaches (incompatibility thesis, conscience absolutism, middle-ground) (Wicclair, 2011) were put forward. Participants tended to favour one approach, but often gave contradictory opinions that made it impossible to ascribe them to one viewpoint. This revealed the complex nature of conscientious objection. Most participants took a radical feminist incompatibility thesis approach before I discussed Wicclair's (2011) three positions. However, following these discussions, the majority of participants voiced opinions that resonated with the liberal feminist middle-ground approach (Wicclair, 2011), as I depict in Figure 11. This could indicate that they had not previously considered this approach. In the following section I present an overview of participants' opinions regarding conscientious objection and the overlap of opinions by perspective.

Firstly, some participants felt that healthcare professionals should not be able to object and adopted a radical feminist incompatibility thesis approach (Wicclair, 2011). Participants who took this approach envisioned conscientious objection as a zero-sum game (Campbell, 2011), whereby service users are directly competing with healthcare professionals regarding rights and freedom. Moreover, the unequal power dynamic between healthcare professionals and service users and the power vested in such professionals by society was seen as problematic as it leaves service users in a disadvantaged position should they encounter a healthcare professional who objects, as

Shahvisi (2018) believes. Rhodes (2006) argues that healthcare professionals should not be able to object because of this power dynamic and the power vested in them by society. Participants outlined duties of healthcare professionals and it was expected that they could 'leave their feelings outside' and remain objective. If they could not leave their feelings outside and had an objection, participants felt that this could be a barrier to abortion care and could have emotional repercussions and impact the outcome, as some service users may change their decision and not abort. Thus, participants' opinions supported the real world findings of Keogh et al. (2019).

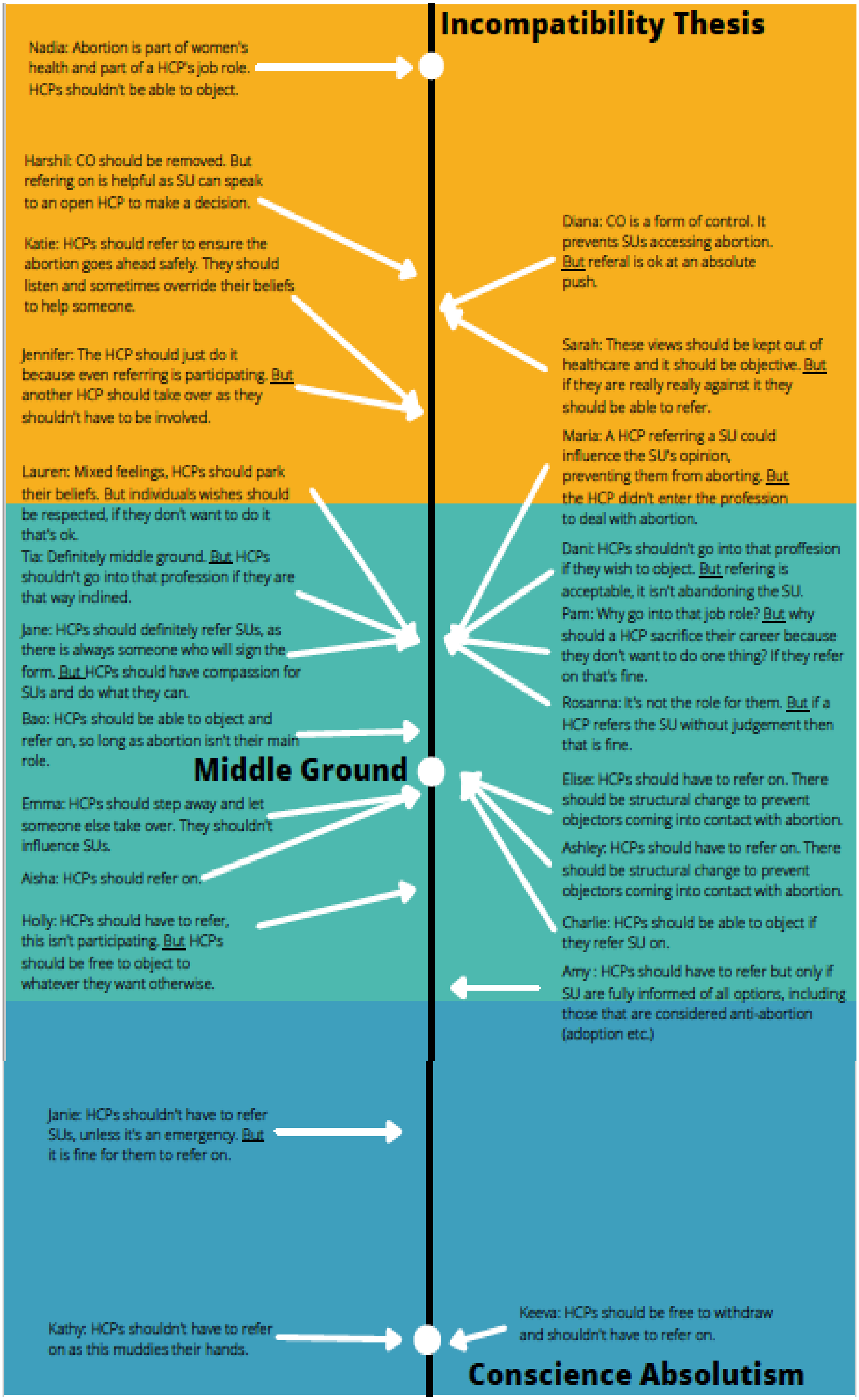
However, whilst many participants voiced these opinions, they also made comments that aligned with a liberal feminist middle-ground approach (Wicclair, 2011). For example, Diana had strong opinions that supported the incompatibility thesis (Wicclair, 2011) but commented that referral, and therefore, conscientious objection could be okay "at an absolute push". Similarly, Sarah strongly supported the incompatibility thesis (Wicclair, 2011) and felt that healthcare professionals' opinions should be kept out of healthcare, though she also believed that "obviously, if that person is really, really against it and doesn't want to participate, then of course, […] I think that should be in place always. The the referral should be there because you know, these women obviously need that assistance. But yeah, it's it's a definite tricky one". Thus, it was evident that although participants had strong feelings supporting the incompatibility thesis, they also understood and appreciated the need for the middle-ground approach (Wicclair, 2011).

Indeed, most participants voiced opinions that fit within the middle-ground approach. It was understood that it is beneficial to protect conscience in medicine (as Wicclair (2011) concluded), that the rights and freedoms of healthcare professionals and service users should be balanced, and that there should be mutual respect between the two parties. To ensure a smooth running service, directly referring and informing participants was seen as an essential duty of objecting healthcare professionals, as proffered by Brock (2008). Directly referring service users whilst abiding by policy and guidelines was not seen as problematic regarding delaying service users' abortions or causing emotional repercussions; rather, participants believed this would benefit both healthcare professionals and service users.

However, although participants endorsed the middle-ground approach, they also made comments that supported both the incompatibility thesis and conscience absolutism (Wicclair, 2011). For example, Tia stated she was “definitely” supportive of the middle-ground approach (Wicclair, 2011), but also commented, “I just don't think they should be in that profession if they are that way inclined”. Similarly, Holly’s opinions fit within the middle-ground approach (Wicclair, 2011), as she noted that healthcare professionals’ rights should be protected and they should be able to object, she also felt that service users should be referred in an effective manner. However, she believed that healthcare professionals should be able to object to anything they want, which is the key message presented by conscience absolutists (Wicclair, 2011).

Few participants supported conscience absolutism, as they saw referral as an essential part of an objecting healthcare professional’s duty (Wicclair, 2011). Kathy was the one participant to consistently voice opinions that fit within the conscience absolutist perspective (Wicclair, 2011), as she believed referring service users makes a healthcare professional morally complicit, and they should not have to refer for this reason. She commented that “it’s almost like a scapegoat, like if I don’t wanna do it, but I can send them to that person over there that will do it. You’re still getting your hands, muddied I guess”. This is one of the key concerns for those who support conscience absolutism, as Cavanaugh (2010), Minerva (2017), Fink et al. (2016), and Trigg (2017) all comment that healthcare professionals should not have to inform and refer service users to preserve their conscience. Amy also supported conscience absolutism for the most part but recognised the need for referral for the system to function. However, she believed that for healthcare professionals to refer, they should be able to give more information to service users and inform them of “the humanity of the unborn child [and]… what the procedure actually entails, not just saying it is a gentle suction, it is not a gentle suction. ‘cause when I woke up from my procedure, I was in pain”. Thus, Amy found the information given to service users by healthcare professionals to be problematic, as she believed that service users are not fully informed, meaning they cannot give informed consent and make an educated decision. According to Amy, this places objecting healthcare professionals in an ethical dilemma as they may believe that they have not given service users the ‘correct’ information and all the alternative options. Minerva (2017) also argued that healthcare professionals should be able to give information on therapeutic options such as counselling, so that service users can make an informed decision.

Figure 10: Overview of participants' views on conscientious objection



Nadia: Abortion is part of women's health and part of a HCP's job role. HCPs shouldn't be able to object.

Harshil: CO should be removed. But refering on is helpful as SU can speak to an open HCP to make a decision.

Katie: HCPs should refer to ensure the abortion goes ahead safely. They should listen and sometimes override their beliefs to help someone.

Jennifer: The HCP should just do it because even referring is participating. But another HCP should take over as they shouldn't have to be involved.

Diana: CO is a form of control. It prevents SUs accessing abortion. But referal is ok at an absolute push.

Sarah: These views should be kept out of healthcare and it should be objective. But if they are really really against it they should be able to refer.

Maria: A HCP referring a SU could influence the SU's opinion, preventing them from aborting. But the HCP didn't enter the profession to deal with abortion.

Lauren: Mixed feelings, HCPs should park their beliefs. But individuals wishes should be respected, if they don't want to do it that's ok.

Tia: Definitely middle ground. But HCPs shouldn't go into that profession if they are that way inclined.

Jane: HCPs should definitely refer SUs, as there is always someone who will sign the form. But HCPs should have compassion for SUs and do what they can.

Bao: HCPs should be able to object and refer on, so long as abortion isn't their main role.

Dani: HCPs shouldn't go into that proffesion if they wish to object. But refering is acceptable, it isn't abandoning the SU.

Pam: Why go into that job role? But why should a HCP sacrifice their career because they don't want to do one thing? If they refer on that's fine.

Rosanna: It's not the role for them. But if a HCP refers the SU without judgement then that is fine.

Emma: HCPs should step away and let someone else take over. They shouldn't influence SUs.

Aisha: HCPs should refer on.

Holly: HCPs should have to refer, this isn't participating. But HCPs should be free to object to whatever they want otherwise.

Elise: HCPs should have to refer on. There should be structural change to prevent objectors coming into contact with abortion.

Ashley: HCPs should have to refer on. There should be structural change to prevent objectors coming into contact with abortion.

Charlie: HCPs should be able to object if they refer SU on.

Amy : HCPs should have to refer but only if SU are fully informed of all options, including those that are considered anti-abortion (adoption etc.)

Janie: HCPs shouldn't have to refer SUs, unless it's an emergency. But it is fine for them to refer on.

Kathy: HCPs shouldn't have to refer on as this muddies their hands.

Keeva: HCPs should be free to withdraw and shouldn't have to refer on.

Conclusion

I analysed participants' opinions of conscientious objection by categorising them into the following sections: healthcare professional and service user entitlement, contextualising conscientious objection, the perceived impact of conscientious objection, the nature of conscientious objection, and organising conscientious objection. Participants often gave a variety of conflicting opinions, which meant they did not fit within one approach (conscience absolutism, middle-ground, incompatibility thesis) (Wicclair, 2011). This highlights the complex nature of conscientious objection. Overall, however, most participants voiced opinions that supported a liberal feminist and middle-ground approach (Wicclair, 2011).

Firstly, when I uncovered the participants' opinions on healthcare professional and service user entitlement, it became evident to me that rights, respect, freedom, and civil liberties were central to this discussion. The most common approach voiced by participants was the middle-ground approach (Wicclair, 2011) which fits within a liberal feminist framework as rights, respect, freedom, and civil liberties were presented as matters that need to be balanced, while they understood healthcare professionals' position of power over the service user. Few participants took a more radical feminist position to argue that conscientious objection should not be allowed in healthcare to protect service users' rights and freedoms, or the alternative polarised position that healthcare professionals' freedoms should be protected to the extent where they do not have to work for an institution that provides abortions.

Participants contextualised conscientious objection in a variety of ways which were underpinned by power, equality, and feminist thought. The ability to access abortion and conscientious objection not obstructing such access in the UK was presented as essential and to be supported by the NHS, which is in line with feminist though. Abortion was understood within the structural context of the UK as a feminist issue that impacts women, and those who took the incompatibility thesis (Wicclair, 2011) position adopted the radical feminist stance that conscientious objection is a patriarchal tool used to control women and is an extension of organised religion. Participants' job roles often contextualised their opinions of conscientious objection. The context of conscientious objection in the UK was presented from an outcome-based approach as participants tended to believe that there will always be someone who can take over service users' care.

There was no consensus regarding how conscientious objection (that adheres to guidelines or breaks guidelines) could impact service users, and whether conscientious objection is inherently judgemental. Some participants believed that healthcare professionals who object often have an alternative agenda and attempt to persuade service users not to abort by discussing medical misinformation and personal moral opinions. Some believed that direct referral would not affect them, and they would be grateful to receive help from another healthcare professional. This resonated with Charlie's real-world experience. Others took a radical feminist incompatibility thesis (Wicclair, 2011) standpoint and believed that the very act of referral would infer judgement and would therefore have emotional and moral repercussions. Moreover, some participants believed that if they or other service users were left without a referral, this could have a negative emotional impact and they would not know what to do, which mirrored some of the participants own experiences.

The nature of conscientious objection was explored by participants in relation to conscience in healthcare, as well as in the nature of particular healthcare professionals' roles. Conscience in healthcare was seen as an important way of maintaining diversity in health and a way of providing empathetic care. There were mixed feelings regarding the nature and duties of healthcare professionals. Some participants believed that they have a duty to provide the service and remain objective, whereas others felt they should be able to object and refer, as they are 'only human'. Moreover, there was conflict over whether GPs and midwives should be involved in abortion; some saw abortion as essential within these role, while others saw it as unrelated.

Finally, there were divergent opinions on whether the system (UK) we currently have in place around conscientious objection is sufficient. Several participants believed we should keep the system we have, whereas others commented that the system needs to change regarding structural issues, referral, regulation, and transparency. Moreover, many participants were not aware of the current self-referral routes. Most participants took the middle-ground approach (Wicclair, 2011) and believed that healthcare professionals should refer service users if they have an objection. However, the opinion that healthcare professionals should not have to refer service users was voiced by a minority. There were also mixed views on whether such professionals should have to inform and explain their objection to service users and if conscientious objection should be regulated in the UK.

Chapter Six: Conclusion

In this chapter, I conclude the research by summarising the key findings in relation to the research questions and discuss the value and contribution thereof. I review the significance of my programme of research, make recommendations for future research, discuss the policy implications, and address the limitations of my programme of research.

Key Findings

In the following section, I address the research questions and how I answered them.

1 What are The Abortion Journey Experiences of Service Users in the UK?

Firstly, I understood the participants' abortion journeys in relation to accessing abortion and the role of healthcare professionals in the abortion process. Most participants lacked knowledge on how to access abortion services. Few participants self-referred to abortion advisory services; instead, they approached their GP or contacted hospital services. The reliance on GPs was evident as participants approached GPs for multiple abortions (Pam, Sarah) and booked to see another GP after lack of referral from the initial GP they visited (Emma, Jess). This highlighted a gap in the general public's education on abortion services and how abortion can be accessed through abortion advisory services by self-referral. Thus, I became aware of the unequal power dynamic between healthcare professionals having knowledge and the participants' reliance upon this relationship, as not all participants were aware of the traditional routes to abortion.

Moreover, the participants generally made the decision to abort before contacting a healthcare professional unless they were coerced to do so by a family member or a partner. However, one participant did wish to obtain information on her options around her pregnancy to decide whether she wanted to abort; she approached a sexual health service, and then her GP once she had made the decision to abort. This behaviour has implications for conscientious objection as healthcare professionals may feel more complicit if they are involved in the decision-making process. On the other hand, service users could be less susceptible to the potential influence of a healthcare professional objecting or attempting to alter their trajectory in cases of ineffective (not adhering to policy and guidelines) conscientious objection if they have already decided to abort. Furthermore, participants decisions to abort were influenced by parental paternalism and partner control more often than healthcare professional paternalism.

There was a lack of transparency around healthcare professionals' actions and reasons for objecting. This confused some participants as they did not know if the healthcare professionals were objecting on conscientious grounds. There were several cases that could have represented a conscientious objection, objection for medical or legal reasons, or could have been due to hospital policy. These instances left participants confused, scared, and in certain cases altered the method, country, and facility in which they accessed an abortion.

Also, participants experienced mixed treatment from both objecting and non-objecting healthcare professionals. I explore the treatment from objecting healthcare professionals in the following section. Participants who did not encounter conscientious objection experienced both judgemental treatment that lacked empathy, and supportive, non-judgemental professional treatment. The way in which participants were treated impacted them on an emotional level, in that positive interactions improved their experience and negative ones had long-term consequences.

2 Have Conscience Clauses in Abortion Legislation Affected UK Service Users' Reproductive Rights Regarding Access to and Experience of Abortion? In what ways?

There was one case of effective conscientious objection where the healthcare professional followed policy and guidelines and referred the participant in a timely manner to another GP (though this is not enshrined in guidelines), after explaining non-judgmentally that they could not be involved in the abortion on grounds of conscience. This indicates that conscientious objection could work in practice from the middle-ground approach (Wicclair, 2011). The participant commented that the interaction with the healthcare professional was positive and did not negatively impact her abortion experience or hinder her access to abortion.

However, in my findings I highlight that the current system in place is failing some service users, as participants discussed how interactions with objectors impacted them. For instance, participants were not always informed of the doctors objection, and that they could access an abortion (indirect referral). This meant that participants had to navigate abortion alone. Indeed, in some cases, anti-abortion medical misinformation and moral opinion were presented as fact to persuade participants to continue the pregnancy. All participants who experienced a clear conscientious objection were able to access abortion in a timely manner, although the situation in which they found themselves was detrimental to their emotional well-being and could be considered negligent.

3 What do Service Users Understand as Constituting 'Participation in Abortion'?

Participants had mixed opinions on what constitutes participation in abortion. Beliefs ranged from: everyone in our society who pays tax is participating in abortion, to, only those who are physically removing the foetus (rather than giving aborticide medication, as this was seen as facilitating an abortion rather than participating) are participating in abortion. Opinions lying between these polar opposites defined participating as: working for the NHS, partaking in auxiliary tasks, any contact with the service user, after care, any involvement in the decision-making process, referring and informing, anything that occurs after the service user has made the decision to abort, being present during the abortion, giving medication, injecting foeticide, and removing the foetus. Participants' opinions on what constitutes participation in abortion did not align with what they believed healthcare professionals should be able to object to, as most participants presented definitions of participation that favoured conscience absolutism but adopted a middle-ground or incompatibility thesis approach (Wicclair, 2011).

4 How do Service Users Situate Themselves Regarding Wicclair's (2011) Three -Part Framework?

Participants gave a variety of conflicting opinions, and therefore did not fit within one approach (conscience absolutism, middle-ground, incompatibility thesis) (Wicclair, 2011). This highlights the complex nature of conscientious objection. Overall, however, most participants took the middle-ground approach (Wicclair, 2011). I have divided the following section into the main themes I uncovered from the research.

Healthcare Professional and Service User Entitlement

There was no clear consensus over whether service users' or healthcare professionals' rights, freedom and need for respect took precedence. Some participants believed the right to abortion took precedence over the right to object, although the majority saw this as a balancing act. Moreover, for the most part, respect was viewed as a two-way process as participants believed that service users should respect healthcare professionals' conscience and religion, while such professionals should respect service users' choice and the need to abort. The freedom to object was seen as extremely important; however, some participants argued that this freedom could directly impinge on the freedoms of service users.

Contextualising Conscientious Objection

Access to abortion and conscientious objection not obstructing access were seen as essential in the UK and supported by the NHS. A comparison was made between the UK and other –less developed – countries regarding individuals who can become pregnant and women's rights. The UK stance was presented as the 'correct' attitude due to healthcare professionals' and service users' entitlements and rights. Moreover, abortion was understood within the structural context of the UK as a feminist issue that impacts women, and conscientious objection was understood as a patriarchal tool to control women. Participants believed that POC and those in poverty are likely to be affected and controlled to a greater extent by conscientious objection. Control over women was also understood as an inevitable extension of religion which was also seen as one of the main reasons healthcare professionals' object. Only some participants viewed religious objection as acceptable. Moreover, the participant's job role often contextualised their opinion on conscientious objection, as those who worked within healthcare believed that professionals in that field should provide abortion care. Finally, the context of abortion in the UK was drawn upon in relation to conscientious objection being a numbers game, as participants tended to believe that conscientious objection is acceptable in the UK as there will always be a non-objector to take over. Participants did not specifically comment on NI.

The Perceived Impact of Conscientious Objection

There was no consensus over how conscientious objection (that adhered to or did not adhere to policy and guidelines) could impact service users and whether conscientious objection is inherently judgemental. Also, participants believed that healthcare professionals who object often have an alternative agenda and attempt to persuade service users not to abort by discussing medical misinformation and personal moral opinions. In practice, this happened to three participants (Katie, Keeva, Emma). Participants posited that such cases may result in service users continuing the pregnancy and having a child. This occurred in one instance (Keeva), although it cannot be confirmed that the healthcare professional had a conscientious objection, as their behaviour could have been a result of the social and legal context of abortion in NI circa 2020.

Moreover, participants' opinions on the impact that direct referral (in line with the middle-ground approach) (Wicclair, 2011) would have on them and other service users varied. Some believed that direct referral would not impact them negatively and they would be grateful to receive help from another healthcare professional. This resonated with Charlie's real-world experience. Others believed the very act of referral would infer judgement and would therefore have emotional and moral repercussions. Furthermore, some participants believed that if they or other service users were left without a referral, it could have a negative emotional impact and they would not know what to do, which mirrored some of the participants' real word experiences.

The Nature of Conscientious Objection

I explored the nature of conscientious objection in relation to conscience in healthcare, and the roles of particular healthcare professionals. Conscience in healthcare was seen as an important way of maintaining diversity in health, and of providing empathetic care. There were mixed feelings regarding the nature and duties of healthcare professionals. Some participants believed that they have a duty to provide the service and remain objective, whereas others felt they should be able to object and refer on as they are 'only human'. Moreover, there was conflict over whether GPs and midwives should be involved in abortion, as some saw abortion as essential within their role, while others saw abortion as unrelated.

Organising Conscientious Objection

There was divergence among participants as to whether the system we currently have in place around conscientious objection is sufficient. Several participants believed that we should keep the system, whereas others argued that the system needs to change regarding structural issues, referral, regulation, and transparency. Moreover, participants were not aware of the current self-referral system in place. In fact, some participants suggested that a separate system needs to be introduced that allows service users to self-refer, thus mirroring what is already in in practice. Overall, most participants took the middle-ground approach (Wicclair, 2011) and believed that healthcare professionals should refer service users if they have an objection. The opinion that such professionals should not have to refer service users was voiced by a minority. There were also mixed views on whether healthcare professionals should have to inform and explain their objection to service users and if conscientious objection should be regulated in the UK.

Overview of Ethical Perspectives

Participants' opinions of conscientious objection varied considerably as aspects of all three approaches (incompatibility thesis, conscience absolutism, middle-ground) (Wicclair, 2011) were in evidence. Participants tended to favour one approach, but often gave contradictory opinions that made it impossible for me to ascribe them to one viewpoint. This highlights the complex nature of conscientious objection. The majority of participants took an incompatibility thesis approach before I discussed Wicclair's (2011) three positions. However, following these discussions, most participants voiced opinions that resonated with the middle-ground approach (Wicclair, 2011). This could indicate that they had not previously considered this perspective.

Research Significance

Previous research that discusses conscientious objection focuses upon the understandings, opinions, and experiences of healthcare professionals based on an ideological commitment to defending or opposing conscientious objection and debates the impact that conscientious objection has without consulting individuals who have accessed abortion. I have discussed such work in detail in Chapter Two.

I offer a unique perspective with this programme of research, as I took a purposive premise, while providing a platform for women and those who can become pregnant to voice their opinions at a time when their voices are largely excluded from the great tradition of Western political philosophy and law-making processes (Dickens, 2014; Levit et al., 2016; Okin, 2013; Paxton & Hughes, 2007). Thus, service users had the opportunity to have their say on matters that have the potential to impact their reproductive rights, while challenging the systematic devaluation of their voices in the context of patriarchy (Beard, 2017). Whilst attempts have been made to include the voices and experiences of women in some areas of law and policy creation (Carra, 2008), I present findings that extend this practice to conscientious objection to abortion.

Furthermore, my programme of research is the first study to uncover service users' views on conscientious objection and the first UK study to provide an in-depth account of how conscientious objection is playing out in practice from the perspectives of service users. Previous British studies that have uncovered conscientious objection from the perspectives of service users (Finnie et al., 2006; Kumar et al., 2004; Purcell, et al., 2014) do not specifically seek to research conscientious objection, or provide an in-depth account on the impact of conscientious objection. Therefore, by conducting this programme of research I offer a unique insight and important contribution to the conscientious objection debate and corresponding policy and guidelines, as I highlight in the following section.

Moreover, the theory and methods I utilised offer a new way of understanding and interpreting opinions and experiences of conscientious objection. I underpinned my programme of research with liberal feminism and Wicclair's (2011) theoretical framework. Thus, understanding and uncovering power and gender inequality lay at the heart of my programme of research, as did the impact of law, policy, and regulation. I presented participants' experiences holistically (McCulliss, 2013), using found poetry. By using this theoretical approach and utilising found poetry my programme of research differed from prior research on abortion provision which has usually adopted a quantitative approach to assess abortion care and improve services.

Policy Recommendations

In the following section I outline several policy recommendations in light of my research findings. Most of my recommendations focus on medical staff.

- An increase in public education on accessing abortion and self-referral to abortion advisory services

The majority of participants did not know how to access an abortion in the UK and were not aware of the self-referral routes. This lack of education meant that participants relied on GPs to access abortion. Educating the public on service availability and the most straightforward ways of accessing abortion could reduce unnecessary contact between service users and GPs and reduce the likelihood of service users encountering an objecting healthcare professional.

- Education and regulation to ensure that healthcare professionals inform service users of their objection and the fact that they can access an abortion, in a non-judgemental way.

Several participants reported that the healthcare professional they approached was not transparent regarding the reason they were objecting, tried to persuade them not to access abortion (on medical (misinformation) and moral grounds), and did not inform them that they could access an abortion, and spoke to them in a judgemental manner. Although correct conduct is presented in guidelines around conscientious objection, further education for healthcare professionals around interactions with service users could reduce improper treatment. Furthermore, the issue could be related to lack of regulation rather than education, in which case further regulation should be brought in to prevent improper treatment. It is unknown whether satisfaction forms available to service users would prove useful in such regulation, as none of the participants who experienced mistreatment reported it.

- Clarity around the GMC policy on referral because of a conscientious objection

I discovered that doctors who had objections were not always referring participants to healthcare professionals who could take over their role. Current policy stipulates that “if it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role” (General Medical Council, 2020a, para 52). This guideline is problematic as there is no guidance for doctors to assess whether it is practical for the service user to make another appointment. Thus, it is at the doctors’ discretion whether they refer the service user, which perpetuates the unequal power dynamic between service users and healthcare professionals. Moreover, in my findings I show that although participants were able to make subsequent appointments, the lack of referral had consequences on an emotional level, which is not considered in the current GMC policy and is exacerbated by the lack of education around accessing abortion. Also, if service users are left to make another appointment, they may be met with another objecting healthcare professional. This could leave service users believing they have nowhere to turn. Although this did not happen to the participants in my programme of research, they were worried that they would come across another objector and struggle to access abortion.

- Clarity around what constitutes participation in abortion

In my findings I reiterate the need to define what constitutes participation in abortion, as a broad range of definitions were offered by participants. A working definition of participation should be created that is specific to the fourth clause of the Abortion Act (1967) and The Abortion (Northern Ireland) Regulations (2022), as I revealed a disconnect between what participants construed as participation in abortion and what they believed healthcare professionals should be able to object to. The role of the healthcare professional should be considered when creating this definition, as participants believed that professionals should be able to object to different elements of the abortion process based on their job role.

Limitations

My programme of research had several limitations which I now discuss and address. Firstly, I used voluntary response sampling to recruit participants; this meant that participants were not representative of the UK service user population. This limited the extrapolation of findings within the UK. In addition, due to the context of abortion and conscientious objection in the UK, my findings may not be applicable to non-UK settings. However, my programme of research was exploratory in nature and worked within the qualitative paradigm. As such, I did not intend to produce generalisable findings.

Most participants (24) accessed abortion in England and resided in an urban area (21). This meant that those attempting to access abortion in a rural or remote areas (4) were underrepresented, as were service users who were based in NI (1) and Wales (1). Similarly, there were no participants who resided in Scotland, and no participants who identified as non-binary or transgender, even though I attempted to recruit specifically from NI and transgender/non-binary populations. Also, due to research budget restrictions, there were no non-English speaking participants. Thus, I was unable to capture the experiences and views of these service users. The perspectives of these groups would have been useful in view of the recent legalisation of abortion in NI, the prediction of high numbers of conscientious objection, and the assessment that conscientious objection disproportionately impacts marginalised individuals, those living in socio-economic deprivation, and those residing in rural areas (Fry-Bowers, 2020). Nevertheless, participants were from a plethora of ethnic backgrounds, therefore, my findings were not limited to white middle-class women.

Furthermore, it is possible that there was a bias towards negative experiences of conscientious objection or accessing abortion, as service users may have been more likely to come forward and discuss their experiences to offload – as Jess commented – and 'tell their story'. However, I may have reduced this somewhat when I introduced the financial incentive, as this would have given potential participants another reason to participate. Moreover, the recruitment process may have led to a certain 'type' of participant, as I posted recruitment material on Facebook, online platforms, and the recruitment website callforparticipants.com. On the positive side, as I recruited participants in this way it meant that individuals who had continued their pregnancy or obtained an abortion from a non-traditional route, could participate in the research, as I may have not reached these individuals if I had recruited through abortion advisory services such as BPAS and MSI.

A further limitation of my programme of research was that I relied on memory recall, and I created no inclusion criteria relating to when the participant accessed or attempted to access abortion. One participant accessed an abortion 37 years prior to interview. This could have meant that her experience of abortion was outdated, and her memory recall may not have been as effective as those who had accessed or attempted to access abortion more recently. However, as I utilised found poetry the experiences of service users could be understood and contextualised on an individual level, hence this could be accounted for to some extent.

Recommendations for Future Research

Future research should continue to uncover service users' experiences and views of conscientious objection in the UK and internationally as part of an undertaking to provide a platform for these voices, as well as to influence policy and guidelines. My programme of research can be used as a springboard to inform the recommended research in this area.

Research should focus on the current impact of conscientious objection in NI in view of recent legal changes around abortion and the prediction of high numbers of objectors due to the religious background of the country. Although the experiences and opinions of service users are paramount, there is a gap in the literature on healthcare professionals' opinions and experiences of conscientious objection regarding the recent shifts in legislation. Thus, research from both service users' and healthcare professionals' perspectives in NI could present a more complete picture of how conscientious objection and abortion services are currently operating. This research would benefit from both qualitative and quantitative studies to ascertain the number of objectors and the impact that conscientious objection could be having in NI.

Secondly, further research should focus on how conscientious objection and abortion provisions are impacting service users in rural and remote areas, in areas of low socio-economic status, and transgender/non-binary service users. Such findings could indicate whether conscientious objection is disproportionately impacting these marginalised populations and provide an insight into these service users' unique experiences. This research should be undertaken in the UK and internationally. It would benefit from a qualitative in-depth method such as semi-structured or narrative interviews to uncover service users' lived experiences from an intersectional feminist perspective.

Thirdly, the body of research on conscientious objection would benefit from a nationwide representative survey of service users to assess the prevalence and impact of conscientious objection. This would provide further insight into how conscientious objection is playing out in the UK more generally. Researchers should consider how to recruit service users who did not access an abortion because of a healthcare professional's conscientious objection, as they will not appear in the abortion statistics.

Concluding Remarks

By undertaking this programme of research, I have elucidated how service users' abortion journeys play out in the UK and how conscientious objection impacts this. Prior to my programme of research, little was known about how conscientious objection is affecting UK service users. Research that sheds light on this is outdated and does not seek to uncover conscientious objection, limiting what it can add to the conscientious objection debate. In my findings I indicate that some service users are being failed by the conscientious objection clause, as although all participants were able to access abortion in a timely manner, the majority of those who experienced conscientious objection were impacted emotionally. I also reveal that education around abortion access for service users and conscientious objection for healthcare professionals needs to be improved. Also, service users would benefit from a form of regulation of conscientious objection to ensure that healthcare professionals are treating them non-judgementally, ensuring transparency when necessary and indirectly referring them to another healthcare professional in an effective manner.

Lastly, I uncovered service users' views on conscientious objection and what constitutes participation in abortion. There has been no previous research in this area. Participants' views varied considerably, presenting liberal and radical feminist stances and all three of Wicclair's (2011) standpoints in relation to: healthcare professional and service user entitlement, contextualising conscientious objection, the impact, nature, and organisation of conscientious objection. This reflected the complex nature of conscientious objection and defining participation. Working definitions of participation should be constructed that are specific to the fourth clause of the Abortion Act (1967) and The Abortion Regulations (Northern Ireland) Regulations (2022), considering the different job roles of healthcare professionals. I believe that taking my programme of research into consideration when creating or altering policy and guidelines around abortion and conscientious objection will help make abortion access fairer and safer for all.

References

Abortion Act, c. 87. (1967). https://www.legislation.gov.uk/ukpga/1967/87/enacted

Abortion Bill, 276. (2018). https://publications.parliament.uk/pa/bills/cbill/2017-2019/0276/18276.pdf

Acosta, K. (2020). Deep reflexivity in conducting sexuality and family research. In M. Kelly & B. Gurr (Eds.), *Feminist research in practice* (pp. 33-39). Rowman & Littlefield Publishers.

Adams, W. (2015). Conducting semi-structured interviews. In K. Newcomer, H. Hatry, & J. Wholey (Eds.), *Handbook of practical program evaluation* (4th ed., pp. 492-505). Jossey-Bass.

Adenitire, J. (2019). *A general legal right to conscientious exemption: Beyond religious privilege* [Doctoral dissertation, University of Cambridge]. Apollo https://doi.org/10.17863/CAM.39265

Aiken, A., Guthrie, K., Schellekens, M., Trussell, J., & Gomperts, R. (2018). Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. *Contraception*, *97*(2), 177-183. https://doi.org/10.1016/j.contraception.2017.09.003

Alegre, M. (2019). Conscious oppression: Conscientious objection in the sphere of sexual and reproductive health. In E. Rivera Lopez & M. Hevia (Eds.), *Controversies in Latin American bioethics* (Vol. 79, pp. 33-51). https://doi.org/10.1007/978-3-030-17963-2_3

Allen, W. (2018). Accommodating conscience without curtailing women’s rights, health, and lives. *The American Journal of Bioethics*, *18*(7), 64-66. https://doi.org/10.1080/15265161.2018.1478030

Altshuler, A. L., Ojanen-Goldsmith, A., Blumenthal, P. D., & Freedman, L. R. (2017). A good abortion experience: A qualitative exploration of women's needs and preferences in clinical care. *Social Science & Medicine*, *191*, 109-116. https://doi.org/https://doi.org/10.1016/j.socscimed.2017.09.010

Altshuler, A. L., & Whaley, N. S. (2018). The patient perspective: Perceptions of the quality of the abortion experience. *Current Opinion in Obstetrics & Gynecology*, *30*(6), 407-413. https://doi.org/10.1097/GCO.0000000000000492

Ancell, A., & Sinnott-Armstrong, W. (2017). How to allow conscientious objection in medicine while protecting patient rights [Review]. *Cambridge Quarterly of Healthcare Ethics*, *26*(1), 120-131. https://doi.org/10.1017/S0963180116000694

Anderson, C., & Kirkpatrick, S. (2016). Narrative interviewing. *International Journal of Clinical Pharmacy*, *38*(3), 631-634. https://doi.org/10.1007/s11096-015-0222-0

Andersson, I.-M., Christensson, K., & Gemzell-Danielsson, K. (2014). Experiences, feelings and thoughts of women undergoing second trimester medical termination of pregnancy. *PLoS ONE*, *9*(12), Article e115957. https://doi.org/10.1371/journal.pone.0115957

Aniteye, P., & Mayhew, S. H. (2013). Shaping legal abortion provision in Ghana: Using policy theory to understand provider-related obstacles to policy implementation. *Health Research Policy and Systems*, *11*(1), 1-14. https://doi.org/10.1186/1478-4505-11-23

Antommaria, A. H. M. (2010). Conscientious objection in clinical practice: Notice, informed consent, referral, and emergency treatment. *Ave Maria Law Review*, *9*(1), 81-99.

Aquinas, T. (1225-1274). *The "Summa theologica" of St. Thomas Aquinas*. Burns, Oates & Washburne, Ltd. http://www.newadvent.org/summa/

Archibald, M., Ambagtsheer, R., Casey, M., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods*, *18*, 1-8. https://doi.org/10.1177/1609406919874596

Ariyanayagam, A. (2022, October 31) *New women's minister defends abortion stance.* BBC. https://www.bbc.co.uk/news/ukpolitics63459465#:~:text=Newly%2Dappointed%20minister%20for%20women,offence%20in%20England%20and%20Wales

Armitage, R. (2022). Abortion in Northern Ireland: Decriminalisation, COVID-19 and recent data. *The Lancet Regional Health - Europe*, *15*, Article 100349. https://doi.org/10.1016/j.lanepe.2022.100349

Aronfreed, J. (1968). *Conduct and conscience: The socialization of internalized control over behavior*. Academic Press.

Arthur, J., Fiala, C., Gemzell Danielsson, K., Heikinheimo, O., & Guðmundsson, J., A. (2017). The dishonourable disobedience of not providing abortion. *The European Journal of Contraception & Reproductive Health Care*, *22*(1), 81-81. https://doi.org/10.1080/13625187.2016.1250255

Autorino, T., Mattioli, F., & Mencarini, L. (2020). The impact of gynecologists' conscientious objection on abortion access. *Social Science Research*, *87*, Article 102403. https://doi.org/10.1016/j.ssresearch.2020.102403

Awoonor-Williams, J. K., Baffoe, P., Aboba, M., Ayivor, P., Nartey, H., Felker, B., Van der Tak, D., Biney, A. A. E. (2020). Exploring conscientious objection to abortion among health providers in Ghana. *International Perspectives on Sexual and Reproductive Health*, *46*, 51-59. https://doi.org/10.1363/46e8920

Awoonor-Williams, J. K., Baffoe, P., Ayivor, P. K., Fofie, C., Desai, S., & Chavkin, W. (2018). Prevalence of conscientious objection to legal abortion among clinicians in northern Ghana. *International Journal of Gynecology & Obstetrics*, *140*(1), 31-36. https://doi.org/10.1002/ijgo.12328

Bacon, L. (2016). Conscientious objection to abortion. *European Journal of Contraception and Reproductive Health Care*, *21*(5), 414-415. https://doi.org/10.1080/13625187.2016.1214256

Badampudi, D., Wohlin, C., & Petersen, K. (2015). Experiences from using snowballing and database searches in systematic literature studies. *Proceedings of the 19th International Conference on Evaluation and Assessment in Software Engineering, China*, https://doi.org/10.1145/2745802.2745818

Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice*, *25*(2), 127-131. https://doi.org/10.1093/fampra/cmn003

Baker, R. (2009). Conscience and the unconscionable. *Bioethics*, *23*(5), ii-iv. https://doi.org/10.1111/j.1467-8519.2009.01735.x

Bandura, A. (1991). Social cognitive theory of moral thought and action. In W. Kurtines & H. Gewirtz (Eds.), *Handbook of moral behaviour and development* (Vol. 1, pp. 45-103). Erlbaum.

Baron, C., Cameron, S., & Johnstone, A. (2015). Do women seeking termination of pregnancy need pre-abortion counselling? *Journal of Family Planning and Reproductive Health Care*, *41*(3), 181-185.

Barriball, K., & While, A. (1994). Collecting data using a semi-structured interview: A discussion paper. *Journal of Advanced Nursing*, *19*(2), 328-335. https://doi.org/10.1111/j.1365-2648.1994.tb01088.x

Bayles, M. (2012). Is physical proximity essential to the psychoanalytic process? An exploration through the lens of Skype? *Psychoanalytic Dialogues*, 22(5), 569-585. https://doi.org/10.1080/10481885.2012.717043

Beard, M. (2017). *Women & power: A manifesto*. Profile Books.

Ben-Moshe, N. (2019). The truth behind conscientious objection in medicine. *Journal of Medical Ethics*, *45*(6), 404-410. https://doi.org/10.1136/medethics-2018-105332

Ben-Moshe, N. (2021). Conscientious objection in medicine: Making it public. *HEC Forum*, *33*(3), 269-289. https://doi.org/10.1007/s10730-020-09401-z

Benjamin, M. (1995). Conscience. In W. Reich (Ed.), *Encyclopedia of bioethics* (Revised ed., pp. 469-473). Simon and Schuster Macmillian.

Bhakuni, H., & Miotto, L. (2021). Conscientious objection to abortion in the developing world: The correspondence argument. *Developing World Bioethics*, *21*(2), 90-95. https://doi.org/10.1111/dewb.12302

Bielefeldt, H. (2017). Conscientious objection in the medical sector towards a holistic human rights approach. In H. Bielefeldt, S. Klotz, M. Schmidhuber, & A. Frewer (Eds.), *Healthcare as a human rights issue: Normative profile, conflicts and implementation* (pp. 201-226). Transcript Verlag. https://doi.org/10.1515/9783839440544-008

Biggs, M. A., Casas, L., Ramm, A., Baba, C. F., & Correa, S. P. (2020). Medical and midwifery students' views on the use of conscientious objection in abortion care, following legal reform in Chile: A cross-sectional study. *BMC Medical Ethics*, *21*(1), 1-11. https://doi.org/10.1186/s12910-020-00484-4

Biggs, M. A., Kaller, S., & Ralph, L. (2020). Barriers accessing abortion care and their association with psychological well-being. *Contraception*, *101*(5), 355. https://doi.org/10.1016/j.contraception.2020.03.010

Birchley, G. (2012). A clear case for conscience in healthcare practice. *Journal of Medical Ethics*, *38*(1), 13-17. doi.org/10.1136/jme.2011.043653

Blackshaw, B., & Rodger, D. (2020). Questionable benefits and unavoidable personal beliefs: Defending conscientious objection for abortion. *Journal of Medical Ethics*, *46*(3), 178-182. https://doi.org/10.1136/medethics-2019-105566

Bloomer, F., Kavanagh, J., Morgan, L., McLaughlin, L., Roberts, R., Savage, W., & Francome, C. (2022). Abortion provision in Northern Ireland: The views of health professionals working in obstetrics and gynaecology units. *BMJ Sexual & Reproductive Health*, *48*(1), 35-40. https://doi.org/10.1136/bmjsrh-2020-200959

Bo, M., Zotti, C., & Charrier, L. (2015). Conscientious objection and waiting time for voluntary abortion in Italy. *European Journal of Contraception and Reproductive Health Care*, *20*(4), 272-282. https://doi.org/10.3109/13625187.2014.990089

Bo, M., Zotti, C., & Charrier, L. (2017). The no correlation argument: Can the morality of conscientious objection be empirically supported? The Italian case. *BMC Medical Ethics*, *18*(1), 1-16. https://doi.org/10.1186/s12910-017-0221-x

Boama, V. (2018). Conscientious objection and the "abortion doctor". *International Journal of Gynecology & Obstetrics*, *143*(3), 263. https://doi.org/10.1002/ijgo.12662

Bowman, M. S., & Schandevel, C. P. (2012). The harmony between professional conscience rights and patients' right of access. *Phoenix Law Review*, *6*, 31-33. https://doi.org/10.2139/SSRN.1998363

Boydell, N., Reynolds-Wright, J. J., Cameron, S. T., & Harden, J. (2021). Women’s experiences of a telemedicine abortion service (up to 12 weeks) implemented during the coronavirus (COVID-19) pandemic: a qualitative evaluation. *BJOG*, *128*(11), 1752-1761. https://doi.org/10.1111/1471-0528.16813

Brack, C. E., Rochat, R. W., & Bernal, O. A. (2017). "It's a race against the clock": A qualitative analysis of barriers to legal abortion in Bogotá, Colombia.

International Perspectives on Sexual and Reproductive Health, *43*(4), 173-182. https://doi.org/10.1363/43e5317

Brader, C. (2020, June 12). *Abortion law in Northern Ireland*. UK Parliament. https://lordslibrary.parliament.uk/abortion-law-in-northern-ireland/

Brauer, S., Yoon, J., & Curlin, F. (2016). US primary care physicians' opinions about conscientious refusal: A national vignette experiment. *Journal of Medical Ethics*, *42*(2), 80-84. https://doi.org/10.1136/medethics-2015-102782

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE Publications Ltd.

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Brazier, M. (1993). Rights and healthcare. In R. Blackburn (Ed.), *Rights of citizenship* (pp. 56-75). Mansell.

British Medical Association. (2020). *Expressing your personal beliefs as a doctor*. https://www.bma.org.uk/advice-and-support/ethics/personal-ethics/expressing-your-personal-beliefs-as-a-doctor

Brock, D. W. (2008). Conscientious refusal by physicians and pharmacists: Who is obligated to do what, and why? *Theoretical Medicine and Bioethics*, *29*(3), 187-200. https://doi.org/10.1007/s11017-008-9076-y

Brownlee, K. (2012). *Conscience and conviction: The case for civil disobedience*. Oxford University Press.

Bryman, A. (2008). *Social research methods* (3rd ed.). Oxford University Press.

Brzozowski, W. (2021). The midwife's tale: Conscientious objection to abortion after Grimmark and Steen. *Oxford Journal of Law and Religion*, *10*(2), 298-316. https://doi.org/10.1093/ojlr/rwab016

Burke, B. (2009). The loss of a physician's freedom of conscience will result in the breakdown of patient autonomy within the doctor-patient relationship. *The*

Linacre Quarterly, *76*(4), 417-426. https://doi.org/10.1179/002436309803889052

Butler, J. (1827). *Sermons—Fifteen sermons preached at the rolls chapel*. Hilliard and Brown. (Original work 1726).

Butler-Kisber, L. (2002). Artful portrayals in qualitative inquiry: The road to found poetry and beyond. *Alberta Journal of Educational Research*, *48*(3), 229-223. https://doi.org/10.11575/ajer.v48i3.54930

Calkin, S., & Berny, E. (2021). Legal and non-legal barriers to abortion in Ireland and the United Kingdom. *The Journal of Medicine Access*, *5*. https://doi.org/10.1177/23992026211040023

Calvin, J. (1845). *The institutes of the Christian religion* (H. Beveridge, Trans.). Christian Classics Ethereal Library. https://www.ccel.org/ccel/c/calvin/institutes/cache/institutes.pdf (Original work 1536).

Campbell, M. (2011). Conscientious objection in medicine: Various myths. *Law and Justice The Christian Law Review*, *166*, 28-36.

Card, R. (2019). The market view on conscientious objection: Overvalued. *Journal of Medical Ethics*, *45*(3), 168-172. https://doi.org/10.1136/medethics-2018-105173

Card, R. F. (2016). In defence of medical tribunals and the reasonability standard for conscientious objection in medicine. *Journal of Medical Ethics*, *42*(2), 73-75. https://doi.org/10.1136/medethics-2015-103037

Carr, E., & Worth, A. (2001). The use of telephone interview for research. *Nursing Times Research*, *6*(1), 511-524. https://doi.org/10.1177/136140960100600107

Carra, A. C. (2008). Creating law and policy with women's voices: Feminism in action. *University of Baltimore Law Forum*, *39*(2), 181-203. http://scholarworks.law.ubalt.edu/lf/vol39/iss2/5

Catechism of the Catholic Church. (1993). Libreria Editrice Vaticana. https://www.vatican.va/archive/ENG0015/_INDEX.HTM

Cavanaugh, T. (2010). Professional conscientious objection in medicine with attention to referral. *Ave Maria Law Review*, *9*(1), 189-206.

Ceva, E. (2015). Political justification through democratic participation: The case for conscientious objection. *Social Theory and Practice*, *41*(1), 26-50. https://doi.org/https://www.jstor.org/stable/pdf/24332317.pdf

Charmaz, K. (2001). Qualitative interviewing and grounded theory analysis. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research* (pp. 675-694). SAGE Publications, Inc.

Chavkin, W. (2013). Conscientious objection to the provision of reproductive healthcare. *International Journal of Gynecology and Obstetrics*, *123*(S3), S39-S40. https://doi.org/10.1016/S0020-7292(13)00601-2

Chavkin, W., Swerdlow, L., & Fifield, J. (2017). Regulation of conscientious objection to abortion: An international comparative multiple-case study. *Health and Human Rights*, *19*(1), 55-68.

Chawla-Duggan, R. (2007). Breaking out, breaking through: Accessing knowledge in a non-western overseas educational setting—Methodological issues for an outsider. *Compare*, *37*(2), 185-200.

Cheng, F. (2018). Dilemmas of Chinese lesbian youths in contemporary mainland China. *Sexuality & Culture*, *22*(1), 190-208. https://doi.org/10.1007/s12119-017-9460-8

Chervenak, F., & McCullough, L. (2008). The ethics of direct and indirect referral for termination of pregnancy. *American Journal of Obstetrics and Gynecology*, *199*(3), 232.E1-232.E3 https://doi.org/10.1016/j.ajog.2008.06.007

Chick, K. (2022, June 30). *Women in Northern Ireland still struggle to access abortion more than 2 years after decriminalization.* Time Magazine. https://time.com/6192022/northern-ireland-abortion-access/

Childress, J. F. (1979). Appeals to conscience. *Ethics*, *89*(4), 315-335. https://doi.org/10.1086/292121

Chilton, G., & Leavy, P. (2014). Arts-based research practice: Merging social research and the creative arts. In P. Leavy (Ed.), *The Oxford handbook of qualitative research* (pp. 403-422). Oxford University Press.

Chong, E., Frye, L. J., Castle, J., Dean, G., Kuehl, L., & Winikoff, B. (2015). A prospective, non-randomized study of home use of mifepristone for medical abortion in the US. *Contraception*, *92*(3), 215-219. https://doi.org/10.1016/j.contraception.2015.06.026

Clark, T., Foster, L., Sloan, L., & Bryman, A. (2021). *Bryman's social research methods* (6th ed.). Oxford University Press.

Clarke, S. (2017). Conscientious objection in healthcare, referral and the military analogy. *Journal of Medical Ethics*, *43*(4), 218-221. https://doi.org/10.1136/medethics-2016-103777

Clarke, V., & Braun, V. (2021). *Thematic analysis: A practical guide*. Sage Publications.

Clipsham, P. (2013). Comparing policies on conscientious refusals: A feminist perspective. *International Journal of Feminist Approaches to Bioethics*, *6*(1), 159-165. https://doi.org/10.2979/intjfemappbio.6.1.159

Cochrane, S. (2014). Doogan and Wood v. NHS Greater Glasgow & Clyde Health Board [2013] CSIH 36 case comment. *Aberdeen Student Law Review*, *5*, 148-150. https://heinonline.org/HOL/P?h=hein.journals/aberde5&i=154

Coleman, P. K., Reardon, D. C., Strahan, T., & Cougle, J. R. (2005). The psychology of abortion: A review and suggestions for future research. *Psychology & Health*, *20*(2), 237-271. https://doi.org/10.1080/0887044042000272921

Collins, C. (2019, December 17). *Northern Ireland bishops say 'unjust' abortion law requires 'conscientious objection'*. Crux Now. https://cruxnow.com/church-in-uk-and-ireland/2019/12/northern-ireland-bishops-say-unjust-abortion-law-requires-conscientious-objection/

Combs, M., Antiel, R., Tilburt, J., Mueller, P., & Curlin, F. (2011). Conscientious refusals to refer: Findings from a national physician survey. *Journal of Medical Ethics*, *37*(7), 397-401. https://doi.org/10.1136/jme.2010.041194

Connolly, M. (2019, October 22). *Northern Ireland abortion law changes: What do they mean?* BBC. https://www.bbc.co.uk/news/uk-northern-ireland-50125124

Conscientious Objection (Medical Activities) Bill, H.L. Bill 14. (2017). https://services.parliament.uk/bills/2017-19/conscientiousobjectionmedicalactivities.html

Contreras, X., van Dijk, M., Sanchez, T., & Smith, P. (2011). Experiences and opinions of health-care professionals regarding legal abortion in Mexico city: A qualitative study. *Studies in Family Planning*, *42*(3), 183-190. http://www.jstor.org/stable/41310728

Cooper, R. J., Wingfield, J., & Bissell, P. (2008). Ethical, religious and factual beliefs about the supply of emergency hormonal contraception by UK community pharmacists. *BMJ Sexual & Reproductive Health*, *34*(1), 47-50. https://doi.org/10.1783/147118908783332122

Coppola, F., Briozzo, L., Nozar, F., Fiol, V., & Greif, D. (2016). Conscientious objection as a barrier for implementing voluntary termination of pregnancy in Uruguay: Gynecologists' attitudes and behavior. *International Journal of Gynecology & Obstetrics*, *134*(Suppl.1), S16-S19. https://doi.org/10.1016/j.ijgo.2016.06.005

Cornwall, A. (2003). Whose voices? Whose choices? Reflections on gender and participatory development. *World Development*, *31*(8), 1325-1342. https://doi.org/10.1016/s0305-750x(03)00086-x

Cotterill, P. (1992). Interviewing women: Issues of friendship, vulnerability, and power. *Women's Studies International Forum*, *15*(5-6), 593-606. https://doi.org/10.1016/0277-5395(92)90061-Y

Cousin, G. (2010). Positioning positionality: The reflexive turn. In M. Savin-Baden & C. Howell Major (Eds.), *New approaches to qualitative research: Wisdom and uncertainty* (pp. 9-18). Routledge.

Cowley, C. (2016a). Conscientious objection and healthcare in the UK: why tribunals are not the answer. *Journal of Medical Ethics*, *42*(2), 69-72. http://dx.doi.org/10.1136/medethics-2015-102692

Cowley, C. (2016b). Conscientious objection and the limits of dialogue. *Philosophy & Social Criticism*, *42*(10), 1004-1014. https://doi.org/10.1177/0191453716631168

Cowley, C. (2016c). A defence of conscientious objection in medicine: A reply to Schuklenk and Savulescu *Bioethics*, *30*(5), 358-364. https://doi.org/10.1111/bioe.12233

Cowley, C. (2017). Conscientious objection in healthcare and the duty to refer. *Journal of Medical Ethics*, *43*(4), 207-212. https://doi.org/10.1136/medethics-2016-103928

Cramer, J. A. (2020). "First, do no harm": Tread carefully where oral history, trauma, and current crises intersect. *The Oral History Review*, *47*(2), 203-213. https://doi.org/10.1080/00940798.2020.1793679

Crespigny, D., Pyman, A., & O'Rourke, A. (2012). Abortion and conscientious objection: The new battleground. *Monash University Law Review*, *38*(3), 87-119.

Criminal Justice Act (Northern Ireland), c.15. (1945). https://www.legislation.gov.uk/apni/1945/15/contents

Culwell, K. R., & Hurwitz, M. (2013). Addressing barriers to safe abortion. *International Journal of Gynecology & Obstetrics*, *121*(Suppl.1), S16-S19. https://doi.org/10.1016/j.ijgo.2013.02.003

Curlin, F. A., Lawrence, R. E., Chin, M. H., & Lantos, J. D. (2007). Religion, conscience, and controversial clinical practices. *New England Journal of Medicine*, *356*(6), 593-600. https://doi.org/10.1056/NEJMsa065316

Czarnecki, D., Anspach, R. R., De Vries, R. G., Dunn, M. D., Hauschildt, K., & Harris, L. H. (2019). Conscience reconsidered: The moral work of navigating participation in abortion care on labor and delivery. *Social Science & Medicine*, *232*, 181-189. https://doi.org/https://doi.org/10.1016/j.socscimed.2019.03.034

Dahlen, S. (2021). Do we need the word 'woman' in healthcare? , *97*(1150), 483-484. https://doi.org/10.1136/postgradmedj-2021-140193

Darzé, O. I., Júnior U. B. (2018). Prevalence, attitudes, and factors motivating conscientious objection toward reproductive health among medical students. *Revista Brasileira De Ginecologia e Obstetricia*, *40*(10), 599-605. https://doi.org/10.1055/s-0038-1673367

Davis, J. M., Haining, C. M., & Keogh, L. A. (2022). A narrative literature review of the impact of conscientious objection by health professionals on women's access to abortion worldwide 2013–2021. *Global Public Health*, *17*(9), 2190-2205. https://doi.org/10.1080/17441692.2021.2020318

Davis, S., Schrader, V., & Belcheir, M. J. (2012). Influencers of ethical beliefs and the impact on moral distress and conscientious objection. *Nursing Ethics*, *19*(6), 738-749. https://doi.org/10.1177/0969733011423409

de Londras, F., Cleeve, A., Rodriguez, M. I., Farrell, A., Furgalska, M., & Lavelanet, A. F. (2023). The impact of 'conscientious objection' on abortion-related outcomes: A synthesis of legal and health evidence. *Health Policy*, *129,* Article 104716. https://doi.org/10.1016/j.healthpol.2023.104716

Deakin, H., & Wakefield, K. (2014). Skype interviewing: Reflections of two PhD researchers. *Qualitative Research*, *14*(5), 603-616. https://doi.org/10.1177/1468794113488126

Deans, Z. (2016). Might a conscience clause be used for non-moral or prejudiced reasons? *Journal of Medical Ethics*, *42*(2), 76-77. https://doi.org/10.1136/medethics-2015-102798

Department of Health and Social Care. (2022, August 23). *At home early medical abortions made permanent in England and Wales*. https://www.gov.uk/government/news/at-home-early-medical-abortions-made-permanent-in-england-and-wales

Department of Health and Social Care. (2023, January 30). *Abortion statistics, England and Wales: 2021*. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021

DeVault, M., L., & Gross, G. (2012). Feminist qualitative interviewing: Experience, talk, and knowledge. In S. N. Hesse-Biber, (Ed.), *The handbook of feminist research: Theory and praxis.* (2nd ed., pp. 206-236). Sage Publications, Inc. https://doi.org/10.4135/9781483384740

Di Stefano, L. M., Wood, K., Mactier, H., Bates, S. E., & Wilkinson, D. (2021). Viability and thresholds for treatment of extremely preterm infants: Survey of UK neonatal professionals. *Archives of Disease in Childhood-Fetal and Neonatal Edition*, *106*(6), 596-602. https://doi.org/10.1136/archdischild-2020-321273

Dickens, B. M. (2014). The right to conscience. In B. M. Dickens, R. J. Cook, & J. N. Erdman (Eds.), *Abortion law in transnational perspective* (pp. 210-238). University of Pennsylvania Press. http://www.jstor.org/stable/j.ctt7zw7tf.13

Dickens, B. M., & Cook, R. J. (2000). The scope and limits of conscientious objection. *International Journal of Gynecology & Obstetrics*, *71*(1), 71-77. https://doi.org/10.1016/s0020-7292(00)00330-1

Diniz, D., Madeiro, A., & Rosas, C. (2014). Conscientious objection, barriers, and abortion in the case of rape: A study among physicians in Brazil. *Reprod Health Matters*, *22*(43), 141-148. https://doi.org/10.1016/s0968-8080(14)43754-6

Domenici, I. (2020). Antigone betrayed? The European court of human rights' decisions on conscientious objection to abortion in the cases of Grimmark v. Sweden and Steen v. Sweden. *European Journal of Health Law*, *28*(1), 26-47. https://doi.org/10.1163/15718093-BJA10032

Doran, F., & Nancarrow, S. (2015). Barriers and facilitators of access to first-trimester abortion services for women in the developed world: A systematic review. *Journal of Family Planning and Reproductive Health Care*, *41*(3), 170-180. https://doi.org/10.1136/jfprhc-2013-100862

Doran, F. M., & Hornibrook, J. (2016). Barriers around access to abortion experienced by rural women in New South Wales, Australia. *Rural and Remote Health*, *16*(1), 3538-3538.

Drury, V., Francis, K., & Chapman, Y. (2007). Taming the rescuer: The therapeutic nature of qualitative research interviews. *International Journal of Nursing Practice*, *13*(6), 383-384. https://doi.org/10.1111/j.1440-172X.2007.00654.x

EastEnders. (2010, May 13). *Stacey has an abortion part 2 - Eastenders - BBC* [Video]. YouTube. https://www.youtube.com/watch?v=_75PycirCok

Eisenberg, N., & Fabes, R. A. (1998). Prosocial development. In W. Damon & N. Eisenberg (Eds.), *Handbook of child psychology, social, emotional, and personality development* (5th ed., Vol. 3. pp. 701-778). John Wiley & Sons Inc.

Eisner, E. W. (1997). The promise and perils of alternative forms of data representation. *Educational Researcher*, *26*(6), 4-10. https://doi.org/10.2307/1176961

Emmerich, N. (2020). After abortion's arrival in Northern Ireland: Conscientious objection and other concerns. *Clinical Ethics*, *15*(2), 71-74. https://doi.org/10.1177/1477750920920549

Esposito, J. L. (1991). *Islam: The straight path*. Oxford University Press.

Faúndes, A., & Miranda, L. (2017). Ethics surrounding the provision of abortion care. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *43*, 50-57. https://doi.org/10.1016/j.bpobgyn.2016.12.005

Favier, M., Greenberg, J. M. S., & Stevens, M. (2018). Safe abortion in South Africa: "We have wonderful laws but we don't have people to implement those laws". *International Journal of Gynecology & Obstetrics*, *143*(Suppl. 4), 38-44. https://doi.org/10.1002/ijgo.12676

Fegan, E. V., & Rebouche, R. (2003). Northern Ireland's abortion law: The morality of silence and the censure of agency. *Feminist Legal Studies*, *11*(3), 221-254. https://doi.org/10.1023/B:FEST.0000004587.37503.5d

Fiala, C., & Arthur, J. (n.d.). *Victims of "CO" –Introduction*. Initiative for Reproductive Health Information. https://www.conscientious-objection.info/category/victims-of-co/

Fiala, C., & Arthur, J. H. (2014). "Dishonourable disobedience" – Why refusal to treat in reproductive healthcare is not conscientious objection. *Woman - Psychosomatic Gynaecology and Obstetrics*, *1*, 12-23. https://doi.org/10.1016/j.woman.2014.03.001

Fiala, C., & Arthur, J. H. (2017a). Refusal to treat patients does not work in any country—even if misleadingly labeled "conscientious objection". *Health and Human Rights*, *19*(2), 299-302. http://www.jstor.org/stable/90016134

Fiala, C., & Arthur, J. H. (2017b). There is no defence for 'conscientious objection' in reproductive health care. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *216*, 254-258. https://doi.org/10.1016/j.ejogrb.2017.07.023

Fiala, C., Gemzell Danielsson, K., Heikinheimo, O., Guðmundsson, J. A., & Arthur, J. (2016). Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care. *The European Journal of Contraception &*

Reproductive Health Care, *21*(3), 201-206. https://doi.org/10.3109/13625187.2016.1138458

Finegan, T. (2019). Conscientious objection to referrals. *Journal of Medical Ethics*, *45*(4), 277-279. https://doi.org/10.1136/medethics-2018-105067

Fink, L., Stanhope, K., Rochat, R., & Bernal, O. (2016). "The fetus is my patient, too": Attitudes toward abortion and referral among physician conscientious objectors in Bogota, Colombia. *International Perspectives on Sexual and Reproductive Health*, *42*(2), 71-80. https://doi.org/10.1363/42e1016

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531-545. research. *British Journal of Occupational Therapy*, *69*(7), 319-326. https://doi.org/10.1177/030802260606900704

Finlay, L. (2006). ‘Rigour’,‘ethical integrity’ or ‘artistry’? Reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy*, *69*(7), 319-326. doi.org/10.1177/030802260606900704

Finnie, S., Foy, R., & Mather, J. (2006). The pathway to induced abortion: Women's experiences and general practitioner attitudes. *BMJ Sexual & Reproductive Health*, *32*(1), 15-18. https://doi.org/10.1783/147118906775275389

Fleming, V., Frith, L., Luyben, A., & Ramsayer, B. (2018). Conscientious objection to participation in abortion by midwives and nurses: A systematic review of reasons. *BMC Medical Ethics*, *19*(1), 1-13. https://doi.org/10.1186/s12910-018-0268-3

Fleming, V., Frith, L., & 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*, *33*, 189–213. https://doi.org/10.1007/s10730-019-09378-4

Fleming, V., Gaidys, U., & Robb, Y. (2003). Hermeneutic research in nursing: Developing a Gadamerian-based research method. *Nursing Inquiry*, *10*(2), 113-120.

Fleming, V., Maxwell, C., & Ramsayer, B. (2020). Accommodating conscientious objection in the midwifery workforce: A ratio-data analysis of midwives, birth and late abortions in 18 European countries in 2016. *Human Resources for Health*, *18*(1), Article 42. https://doi.org/10.1186/s12960-020-00482-y

Fleming, V., Ramsayer, B., & Škodič Zakšek, T. (2018). Freedom of conscience in Europe? An analysis of three cases of midwives with conscientious objection to abortion. *Journal of Medical Ethics*, *44*(2), 104-108. https://doi.org/10.1136/medethics-2016-103529

Fletcher, R. (2016). Conscientious objection, harm reduction and abortion care. In M. Donnelly & C. Murray (Eds.), *Ethical and legal debates in Irish healthcare* (pp. 24-40). Manchester University Press. https://doi.org/10.7228/manchester/9780719099465.003.0003

Frank, J. E. (2011). Conscientious refusal in family medicine residency training. *Family Medicine*, *43*(5), 330-333.

Freedman, L. R., Landy, U., & Steinauer, J. (2008). When there's a heartbeat: Miscarriage management in Catholic-owned hospitals. *American Journal of Public Health*, *98*(10), 1774-1778. https://doi.org/10.2105/AJPH.2007.126730

Freeman, E., & Coast, E. (2019). Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices. *Social Science & Medicine*, *221*, 106-114. https://doi.org/10.1016/j.socscimed.2018.12.018

French, V. A., Anthony, R. S., Berrios, S. E., Crockett, L. D., & Steinauer, J. E. (2016). A sense of obligation: Attitudes and referral practices for abortion services among women's health providers in a rural US state. *Clinical Obstetrics, Gynecology and Reproductive Medicine*, *2*(4), 204-210. https://doi.org/10.15761/COGRM.1000151

Freud, S. (1935). *A general introduction to psychoanalysis*. Modern Library.

Fry, C. L., Hall, W., Ritter, A., & Jenkinson, R. (2006). The ethics of paying drug users who participate in research: A review and practical recommendations. *Journal of Empirical Research on Human Research Ethics*, *1*(4), 21-35. https://doi.org/10.1525/jer.2006.1.4.21

Fry-Bowers, E. K. (2020). A matter of conscience: Examining the law and policy of conscientious objection in health care. *Policy, Politics, & Nursing Practice*, *21*(2), 120-126. https://doi.org/10.1177/1527154420926156

Fuss, P. (1964). Conscience. *Ethics*, *74*(2), 111-120. https://doi.org/10.1086/291483

Fylan, F. (2005). Semi-structured interviewing. In J. Miles & P. Gilbert (Eds.), *A handbook of research methods for clinical and health psychology* (Vol. 5, pp. 65-78). Oxford University Press.

Gale, J. (1992). When research interviews are more therapeutic than therapy interviews. *The Qualitative Report*, *1*(4), 1-4. https://doi.org/10.46743/2160-3715/1992.2036

General Medical Council. (2020a). *Good medical practice*. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-3---communication-partnership-and-teamwork

General Medical Council. (2020b). *Personal beliefs and medical practice*. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice

Gentleman, A. (2017, September 7). *No prosecution risk for Northern Ireland medical staff over abortion referrals*. The Guardian. https://www.theguardian.com/uk-news/2017/sep/07/no-prosecution-risk-for-northern-ireland-medical-staff-over-abortion-referrals

Gettig, E. (2009). A remembrance of Dr. George Tiller. *Journal of Genetic Counselling*, *18*(5), 404-406. https://doi.org/10.1007/s10897-009-9257-5

Gillam, S. (2022). *Quality improvement in primary care: The essential guide*. CRC Press.

Giubilini, A. (2014). The paradox of conscientious objection and the anemic concept of 'conscience': Downplaying the role of moral integrity in health care. *Kennedy Institute of Ethics Journal*, *24*(2), 159-185. https://doi.org/10.1353/ken.2014.0011

Giubilini, A. (2016). Conscience. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy*. Stanford University. https://plato.stanford.edu/archives/win2016/entries/conscience/

Giubilini, A. (2017). Objection to conscience: An argument against conscience exemptions in healthcare. *Bioethics*, *31*(5), 400-408. https://doi.org/10.1111/bioe.12333

Glauser, W. (2014). Controversy over doctors' right to say ‘no’. *Canadian Medical Association Journal*, *186*(13), E483–E484. https://doi.org/10.1503/cmaj.109-4872

Glenza, J., Pengelly, M., & Levin, S. (2022, June 24). *US supreme court overturns abortion rights, upending Roe v Wade*. The Guardian. https://www.theguardian.com/world/2022/jun/24/roe-v-wade-overturned-abortion-summary-supreme-court

Gray, B. (2010). Emotional labour, gender and professional stereotypes of emotional and physical contact, and personal perspectives on the emotional labour of nursing. *Journal of Gender Studies*, *19*(4), 349-360. https://doi.org/10.1080/09589236.2010.514207

Gray, L., Wong-Wylie, G., Rempel, G., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report*, *25*(5), 1292-1301. https://doi.org/10.46743/2160-3715/2020.4212

Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland), 68 UKSC 2013/0124. (UK Supreme Court 2014). https://www.supremecourt.uk/cases/docs/uksc-2013-0124-judgment.pdf

Green, B. (2017). Use of the Hippocratic or other professional oaths in UK medical schools in 2017: Practice, perception of benefit and principlism. *British Medical Council Research Notes*, *10*(1), Article 777. https://doi.org/10.1186/s13104-017-3114-7

Green, K. (Host) (2020, March 27). Barbara Gurr and Maura Kelly on feminist research methods [Audio Podcast Episode]. In *Give methods a chance*. https://thesocietypages.org/methods/2020/03/27/barbara-gurr-and-maura-kelly-on-feminist-research-methods/

Greenawalt, K. (2010). Refusals of conscience: What are they and when should they be accommodated. *Ave Maria Law Review*, *9*, 47-65.

Griffin, N. (2019). Patients, not criminals: Northern Ireland grapples with how to provide legal abortion. *BMJ*, *367,* Article 16318. https://doi.org/10.1136/bmj.l6318

Griffith, R. (2016). Procuring a miscarriage. *British Journal of Midwifery*, *24*(2), 114-115. https://doi.org/10.12968/bjom.2016.24.2.144

Grindlay, K., & Grossman, D. (2017). Telemedicine provision of medical abortion in Alaska: Through the provider’s lens. *Journal of Telemedicine and Telecare*, *23*(7), 680-685. https://doi.org/10.1177/1357633X16659166

Grossman, D., & Grindlay, K. (2017). Safety of medical abortion provided through telemedicine compared with in person. *Obstetrics & Gynecology*, *130*(4), 778-782. https://doi.org/10.1097/AOG.0000000000002212

Haaland, M. E., Haukanes, H., Zulu, J. M., Moland, K. M., & Blystad, A. (2020). Silent politics and unknown numbers: Rural health bureaucrats and Zambian abortion policy. *Social Science & Medicine*, *251*, Article 112909. https://doi.org/10.1016/j.socscimed.2020.112909

Håkansson, D. I., Ouis, P., & Ragnar, M. E. (2021). Navigating the minefield: Women's experiences of abortion in a Country with a conscience clause—The case of Croatia. *Journal of International Women's Studies*, *22*(1), 166-180. https://vc.bridgew.edu/jiws/vol22/iss1/10/

Hampton, S. B., Cavalier, J., & Langford, R. (2015). The influence of race and gender on pain management: A systematic literature review. *Pain Management Nursing*, *16*(6), 968-977.

Harden, A., & Ogden, J. (1999). Young women’s experiences of arranging and having abortions. *Sociology of Health & Illness*, *21*(4), 426-444. https://doi.org/10.1111/1467-9566.00165

Harries, J., Cooper, D., Strebel, A., & Colvin, C. J. (2014). Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. *Reproductive Health*, *11*(1), Article 16. https://doi.org/10.1186/1742-4755-11-16

Harris, J. R. (1995). Where is the child's environment? A group socialization theory of development. *Psychological Review*, *102*(3), 458-489. https://doi.org/10.1037/0033-295X.102.3.458

Harris, L. F., Awoonor-Williams, J. K., Gerdts, C., Urbano, L. G., Velez, A. C. G., Halpern, J., Prata. N., Baffoe, P. (2016). Development of a conceptual model and survey instrument to measure conscientious objection to abortion provision.

PLoS ONE, *11*(10), Article e0164368. https://doi.org/10.1371/journal.pone.0164368

Harris, L. F., Halpern, J., Prata, N., Chavkin, W., & Gerdts, C. (2018). Conscientious objection to abortion provision: Why context matters. *Global Public Health*, *13*(5), 556-566. https://doi/full/10.1080/17441692.2016.1229353

Hawkesworth, M., & Disch, L. (2016). Feminist theory: Transforming the known world. In M. Hawkesworth & L. Disch (Eds.), *The Oxford handbook of feminist theory* (pp. 1-15). Oxford University Press.

Haynes, S. (2020, March 30). *U.K. government changes regulations on abortion pills during the coronavirus outbreak.* Time Magazine. https://time.com/5812433/abortion-coronavirus-outbreak-uk/

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, *12*(4), 335-344. https://doi.org/10.1080/13645570802246724

Heaton, J., Day, J., & Britten, N. (2015). Collaborative research and the co-production of knowledge for practice: An illustrative case study. *Implementation Science*, *11*(1), 1-10. https://doi.org/10.1186/s13012-016-0383-9

Heino, A., Gissler, M., Apter, D., & Fiala, C. (2013). Conscientious objection and induced abortion in Europe. *European Journal of Contraception and Reproductive Health Care*, *18*(4), 231-233. https://doi.org/10.3109/13625187.2013.819848

Hesche, A. J. (1955). *God in search of man: A philosophy of Judaism*. Farrar, Straus and Giroux.

Hewitt-Taylor, J. (2002). Inside knowledge: Issues in insider research. *Nursing Standard*, *16*(46), 33-35. https://doi.org/10.7748/ns.16.46.33.s5

Hildingsson, I., & Fenwick, J. (2015). Swedish midwives' perception of their practice environment–A cross sectional study. *Sexual & Reproductive Healthcare*, *6*(3), 174-181. https://doi.org/10.1016/j.srhc.2015.02.001

Hillen, J., Mallon, S., & Morgan, S. (2022). *Northern Ireland hospital based termination of pregnancy statistics 2021/22*. Department of Health. https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-termination-of-pregnancy-stats-20-21.pdf

Hiller, J. (2016). Epistemological foundations of objectivist and interpretivist research. In B. L. Wheeler & K. M. Murphy (Eds.), *An Introduction to Music Therapy Research* (pp. 99-127). Barcelona Publishers.

Hoffmann, J., & Johnson, S. (2005). Attitudes toward abortion among religious traditions in the United States: Change or continuity? *Sociology of Religion*, *66*(2), 161-182.

Homaifar, N., Freedman, L., & French, V. (2017). "She's on her own": A thematic analysis of clinicians' comments on abortion referral. *Contraception*, *95*(5), 470-476. https://doi.org/10.1016/j.contraception.2017.01.007

Horowitz, R. (1983). *Honor and the American dream: Culture and identity in a Chicano community*. Rutgers University Press.

Horton, J., Macve, R., & Struyven, G. (2004). Qualitative research: Experiences in using semi-structured interviews. In C. Humphrey & B. Lee (Eds.), *The real life guide to accounting research: A behind the scenes view of using qualitative research methods* (pp. 339-357). Elsevier.

Hough, L., & Moore, H. (2023, January 26). *UK facing crisis point in abortion provision, experts say.* The Guardian. https://www.theguardian.com/society/2023/jan/26/uk-facing-crisis-point-in-abortion-provision-experts-say

Hughes, J. A. (2017). Conscientious objection in healthcare: Why tribunals might be the answer. *Journal of Medical Ethics*, *43*(4), 213-217. https://doi.org/10.1136/medethics-2015-102970

Hughes, J. A. (2018). Conscientious objection, professional duty and compromise: A response to Savulescu and Schuklenk. *Bioethics*, *32*(2), 126-131. https://doi.org/10.1111/bioe.12410

Human Fertilisation and Embryology Act, c. 37. (1990). https://fra.europa.eu/en/law-reference/human-fertilisation-and-embryology-act-1990-ammended-human-fertilisation-and#:~:text=Home-,Human%20Fertilisation%20and%20Embryology%20Act%201990%20(as%20ammended%20by%20the,Fertilisati on%20and%20Embryology%20Act%202008)&text=Section%203%20Prohibitions%20in%20connection,in%20pursuance%20of%20a%20licence

Human Fertilisation and Embryology Act, c. 22. (2008). https://www.legislation.gov.uk/ukpga/2008/22/contents

Human Rights Act, c. 42. (1998). http://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/I/chapter/8

Hutchinson, S. A., Wilson, M. E., & Wilson, H. S. (1994). Benefits of participating in research interviews. *Image: The Journal of Nursing Scholarship*, *26*(2), 161-166. https://doi.org/10.1111/j.1547-5069.1994.tb00937.x

Infant Life (Preservation) Act, c. 34. (1929). https://www.legislation.gov.uk/ukpga/Geo5/19-20/34/section/1

Innes, R. A. (2009). "Wait a second. Who are you anyways?" The insider/outsider debate and American Indian studies. *American Indian Quarterly*, *33*(4), 440-461. https://www.jstor.org/stable/pdf/40388481.pdf

Jeffreys, S. (2012). *Man's dominion: Religion and the eclipse of women's rights in world politics*. Routledge.

Jenkins, K., Narayanaswamy, L., & Sweetman, C. (2019). Introduction: Feminist values in research. *Gender & Development*, *27*(3), 415-425. https://doi.org/10.1080/13552074.2019.1682311

Jenkinson, B., Kruske, S., & Kildea, S. (2017). The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis. *Midwifery*, *52*, 1-10.

Jeong-Hee, K. (2016). *Understanding narrative inquiry: The crafting and analysis of stories as research.* Sage Publications, Inc. https://doi.org/10.4135/9781071802861

Johnson, B. R., Kismodi, E., Dragoman, M. V., & Temmerman, M. (2013). Conscientious objection to provision of legal abortion care. *International Journal of Gynecology & Obstetrics*, *123*(Suppl.3), S60-S62. https://doi.org/10.1016/S0020-7292(13)60004-1

Jones-Nosacek, C. (2022). Referral vs transfer of care: Ethical options when values differ. *The Linacre Quarterly*, *89*(1), 36-46. https://doi.org/10.1177/00243639211055970

Kable, A., Pich, J., & Maslin-Prothero, S. (2012). A structured approach to documenting a search strategy for publication: A 12 step guideline for authors. *Nurse Education Today*, *32*(8), 878-886. https://doi.org/10.1016/j.nedt.2012.02.022

Karabulut, S. D., Gül, Ş., Keleş, Ş., Baykara, Z. G., & Yalım, N. Y. (2022). Nurses' attitudes toward, perceptions of, and experiences with conscientious objection. *Nursing Ethics*, 29(7-8), 1615-1633. https://doi.org/10.1177/09697330221085771

Kartch, F. (2017). Narrative interviewing. In M. Allen (Ed.), *The SAGE encyclopedia of communication research methods* (Vol. 1-4.). https://doi.org/10.4135/9781483381411

Kelly, M. (2020). Putting feminist research into practice. In M. Kelly & B. Gurr (Eds.), *Feminist research in practice* (pp. 1-13). The Rowman & Littlefield Publishing Group, Inc.

Keogh, L. A., Croy, S., Newton, D., Hendron, M., & Hill, S. (2019). General practitioner knowledge and practice in relation to unintended pregnancy in the Grampians region of Victoria, Australia. *Rural and Remote Health*, *19*(4). https://doi.org/10.22605/RRH5156

Keogh, L. A., Gillam, L., Bismark, M., Webster, K. M. A., Bayly, C., & Newton, D. (2019). Conscientious objection to abortion, the law and its implementation in Victoria, Australia: Perspectives of abortion service providers. *BMC Medical Ethics*, *20*, Article 11 https://doi.org/10.1186/s12910-019-0346-1

Kero, A., Högberg, U., & Lalos, A. (2004). Wellbeing and mental growth—long-term effects of legal abortion. *Social Science & Medicine*, *58*(12), 2559-2569. https://doi.org/10.1016/j.socscimed.2003.09.004

Killen, M., Lee-Kim, J., McGlothlin, H., Stangor, C., & Helwig, C. C. (2002). How children and adolescents evaluate gender and racial exclusion. *Monographs of the Society for Research in Child Development*, *64*(4), i-129.

Kimport, K., Cockrill, K., & Weitz, T. A. (2012). Analyzing the impacts of abortion clinic structures and processes: A qualitative analysis of women's negative experience of abortion clinics. *Contraception*, *85*(2), 204-210. https://doi.org/10.1016/j.contraception.2011.05.020

Kirsch, G. (2005). Friendship, friendliness, and feminist fieldwork. *Signs: Journal of Women in Culture and Society*, *30*(4), 2163-2172. https://doi.org/10.1086/428415

Kishen, M., & Stedman, Y. (2010). The role of advanced nurse practitioners in the availability of abortion services. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *24*(5), 569-578. https://doi.org/10.1016/j.bpobgyn.2010.02.014

Kohlberg, L. (1969). Stage and sequence: The cognitive developmental approach to socialisation. In D. Goslin (Ed.), *Handbook of socialisation theory and research* (pp.347-480). Rand McNally.

Kominers, S., Stanton, C., Wu, A., & Gonzalez, G. (2020, August). *Zoom video communications: Eric Yuan's leadership during COVID-19*. Harvand Buisness School. https://www.hbs.edu/faculty/Pages/item.aspx?num=58693

Kumar, U., Baraitser, P., Morton, S., & Massil, H. (2004). Decision making and referral prior to abortion: A qualitative study of women's experiences. *Journal of Family Planning and Reproductive Health Care*, *30*(1), 51-54. https://doi.org/10.1783/147118904322702009

Küng, S. A., Wilkins, J. D., de León, F. D., Huaraz, F., & Pearson, E. (2021). "We don't want problems": Reasons for denial of legal abortion based on conscientious objection in Mexico and Bolivia. *Reproductive Health*, *18*, Article 44. https://doi.org/10.1186/s12978-021-01101-2

Kvale, S. (1995). The social construction of validity. *Qualitative Inquiry*, *1*(1), 19-40. https://doi.org/10.1177/107780049500100103

Kvale, S., & Brinkmann, S. (2014). *Interviews: Learning the craft of qualitative research interviewing* (3rd ed.). SAGE Publications, Inc.

Lahman, M. K., Richard, V. M., & Teman, E. D. (2019). ish: How to write poemish (research) poetry. *Qualitative Inquiry*, *25*(2), 215-227. https://doi.org/10.1177/1077800417750182

Lahman, M. K. E., Geist, M. R., Rodriguez, K. L., Graglia, P. E., Richard, V. M., & Schendel, R. K. (2010). Poking around poetically: Research, poetry, and trustworthiness. *Qualitative Inquiry*, *16*(1), 39-48. https://doi.org/10.1177/1077800409350061

Lamb, C. (2016). Conscientious objection: Understanding the right of conscience in health and healthcare practice. *New Bioethics*, *22*(1), 33-44. https://doi.org/10.1080/20502877.2016.1151252

Lasagna, L. (1964). *The Hippocratic oath: Modern version*. NOVA. https://www.pbs.org/wgbh/nova/doctors/oath_modern.html#:~:text=May%20I%20always%20act%20so,in%20many%20medical%20schools%20today.

Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. Routledge.

Lawrence, E., & Curlin, F. (2009). Physicians' beliefs about conscience in medicine: A national survey. *Academic Medicine*, *84*(9), 1276-1282. https://doi.org/10.1097/ACM.0b013e3181b18dc5

Lawrence, R., & Curlin, F. (2007). Clash of definitions: Controversies about conscience in medicine. *The American Journal of Bioethics*, *7*(12), 10-14.

Lee, E., Clements, S., Ingham, R., & Stone, N. (2004). *A matter of choice?: Explaining national variations in teenage abortion and motherhood*. Joseph Rowntree Foundation. https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/1859351824.pdf

Lee, E., Macvarish, J., & Sheldon, S. (2017, February). Doctors who provide abortion: Their values and professional identity. *University of Kent*. https://blogs.kent.ac.uk/parentingculturestudies/files/2012/06/Prelim-Findings-Final-Feb-2017.pdf

Lema, V. M. (2012). Conscientious objection and reproductive health service delivery in sub-Saharan Africa. *African Journal of Reproductive Health*, *16*(1), 15-21. https://www.jstor.org/stable/23317028

Levit, N., Verchick, R. R., & Minow, M. (2016). *Feminist legal theory* (2nd ed.). NYU Press.

Lie, M. L., Robson, S. C., & May, C. R. (2008). Experiences of abortion: A narrative review of qualitative studies. *BMC Health Services Research*, *8*(1), 1-9. https://doi.org/10.1186/1472-6963-8-150

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications, Inc.

Lincoln, Y. S., & Guba, E. G. (1989). Ethics: The failure of positivist science. *The Review of Higher Education*, *12*(3), 221-240. https://doi.org/10.1353/rhe.1989.0017

Love, G. (2017). *Contextualising abortion: A life narrative study of abortion and social class in neoliberal England* [Doctoral dissertation, University of Sussex]. University of Sussex Repository. http://sro.sussex.ac.uk/id/eprint/73444/

Low, S. T., Chen, Z. E., & Cameron, S. (2020). Women's experiences of self-referral to an abortion service: Qualitative study. *BMJ Sexual & Reproductive Health*, *47*(1), 37-42. https://doi.org/10.1136/bmjsrh-2019-200568

Lynch, H. F. (2008). *Conflicts of conscience in health care an institutional compromise.* The MIT Press. https://doi.org/10.2307/j.ctt5hhf0c.15

Lyus, R. J. (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*, *43*(4), 250-252. https://doi.org/10.1136/medethics-2016-103643

Macdonald, B., & Walker, R. (1977). Case study and the social philosophy of educational research. In D. Hamilton (Ed.), *Beyond the numbers game: A reader in educational evaluation* (pp. 181-189). MacMillan.

Madeiro, A., Rufino, A., Santos, P., Bandeira, G., & Freitas, I. (2016). Objeção de consciência e aborto legal: Atitudes de estudantes de medicina. *Revista Brasileira de Educação Médica*, *40*(1), 86-92. https://doi.org/10.1590/1981-52712015v40n1e02382014

Mainey, L., O'Mullan, C., Reid-Searl, K., Taylor, A., & Baird, K. (2020). The role of nurses and midwives in the provision of abortion care: A scoping review. *Journal of Clinical Nursing*, *29*(9-10), 1513-1526. https://doi.org/10.1111/jocn.15218

Makleff, S., Labandera, A., Chiribao, F., Friedman, J., Cardenas, R., Sa, E., & Baum, S. E. (2019). Experience obtaining legal abortion in Uruguay: Knowledge, attitudes, and stigma among abortion clients. *BMC Women's Health*, *19*(1), 1-10. https://doi.org/10.1186/s12905-019-0855-6

MSI Reproductive Choices. (2020). *Abortion and vasectomy referrals.* https://www.msichoices.org.uk/for-professionals/referrals/

Marsh, D., & Furlong, P. (2002). A skin not a sweater: Ontology and epistemology in political science. In D. Marsh & G. Stoker (Eds.), *Theory and methods in political Science* (pp. 17-41). Pallgrave McMillan.

Marsh, J. (2014). Conscientious refusals and reason-giving. *Bioethics*, *28*(6), 313-319. https://doi.org/10.1111/bioe.12012

Martin, L. A., Debbink, M., Hassinger, J., Youatt, E., & Harris, L. H. (2014). Abortion providers, stigma and professional quality of life. *Contraception*, *90*(6), 581-587. https://doi.org/10.1016/j.contraception.2014.07.011

Maxwell, C., Ramsayer, B., & Fleming, V. (2022). It's about finding a balance…exploring conscientious objection to abortion with UK midwives. *Midwifery*, *112*, Article 103416. https://doi.org/10.1016/j.midw.2022.103416

May, R. A. B. (2014). When the methodological shoe is on the other foot: African American interviewer and White interviewees. *Qualitative Sociology*, *37*(1), 117-136.

McCulliss, D. (2013). Poetic inquiry and multidisciplinary qualitative research. *Journal of Poetry Therapy*, *26*(2), 83-114.

McLemore, M. R., Desai, S., Freedman, L., James, E. A., & Taylor, D. (2014). Women know best—findings from a thematic analysis of 5,214 surveys of abortion care experience. *Women's Health Issues*, *24*(6), 594-599. https://doi.org/10.1016/j.whi.2014.07.001

McLeod, C. (2008). Referral in the wake of conscientious objection to abortion. *Hypatia*, *23*(4), 30-47. https://doi.org/10.1111/j.1527-2001.2008.tb01432.x

Meaney, J., Casini, M., & Spagnolo, A. G. (2012). Objective reasons for conscientious objection in health care. *The National Catholic Bioethics Quarterly*, *12*(4), 611-620. https://doi.org/10.5840/ncbq20121246

Merner, B., Haining, C. M., Willmott, L., Savulescu, J., & Keogh, L. A. (2023). Institutional objection to abortion: A mixed-methods narrative review. *Women's Health*, *19*, 17455057231152373. https://doi.org/10.1177/17455057231152373

Meyers, C., & Woods, R. D. (1996). An obligation to provide abortion services: What happens when physicians refuse? *Journal of Medical Ethics*, *22*(2), 115-120. https://doi.org/10.1136/jme.22.2.115

Meyers, C., & Woods, R. D. (2007). Conscientious objection? Yes, but make sure it is genuine. *American Journal of Bioethics*, *7*(6), 19-20. https://doi.org/10.1080/15265160701347270

Michel, A. R., Kung, S., López-Salm, A., & Navarrete, S. A. (2020). Regulating conscientious objection to legal abortion in Argentina: Taking into consideration its uses and consequences. *Health and Human Rights*, *22*(2), 271–283.

Minerva, F. (2015). Conscientious objection in Italy. *Journal of Medical Ethics*, *41*(2), 170-173. https://doi.org/10.1136/medethics-2013-101656

Minerva, F. (2017). Conscientious objection, complicity in wrongdoing, and a not-so-moderate approach. *Cambridge Quarterly of Healthcare Ethics*, *26*(1), 109-119. https://doi.org/10.1017/S0963180116000682

Mitchell, C. (2013). *Religion, identity and politics in Northern Ireland: Boundaries of belonging and belief*. Ashgate Publishing, Ltd.

Mitchell, M. (2011). A reflection on the emotional potential of qualitative interviewing. *British Journal of Midwifery*, *19*(10), 653-657. https://doi.org/10.12968/bjom.2011.19.10.653

Montero, A., Ramirez-Pereira, M., Robledo, P., Casas, L., Vivaldi, L., & Gonzalez, D. (2022). Conscientious objection as structural violence in the voluntary termination of pregnancy in Chile. *Frontiers in Psychology*, *13*, 1007025. https://doi.org/10.3389/fpsyg.2022.1007025

Montero, A., & Villarroel, R. (2018). A critical review of conscientious objection and decriminalisation of abortion in Chile. *Journal of Medical Ethics*, *44*(4), 279-283. https://doi.org/10.1136/medethics-2017-104281

Moodley, K. (2008). Feticide and late termination of pregnancy: Five levels of ethical conflict. *Obstetrics and Gynaecology Forum*, *18*(3), 93-95. https://doi.org/10.4314/ogf.v18i3.30597

Morgan, E. (2022). *Written statement: Arrangements for early medical abortion at home*. Wales: Llywody Cymraeg Welsh Government https://gov.wales/written-statement-arrangements-early-medical-abortion-home

Morton, N. T., & Kirkwood, K. W. (2009). Conscience and conscientious objection of health care professionals refocusing the issue. *HEC Forum*, *21*(4), 351-364.

Müller, A., Röhrs, S., Hoffman-Wanderer, Y., & Moult, K. (2016). "You have to make a judgment call".–Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa. *Social Science & Medicine*, *148*, 71-78. https://doi.org/10.1016/j.socscimed.2015.11.048

Munthe, C. (2017). Conscientious refusal in healthcare: The Swedish solution. *Journal of Medical Ethics*, *43*(4), 257-259. https://doi.org/10.1136/medethics-2016-103752

Neal, M. (2014). The scope of the conscience-based exemption in section 4(1) of theAbortion Act 1967: Doogan and Wood V NHS Greater Glasgow Health Board [2013] CSIH 36. *Medical Law Review*, *22*(3), 409-421. https://doi.org/10.1093/medlaw/fwt041

Neal, M. (2015). When conscience isn't clear: Greater Glasgow Health Board v Doogan and another [2014] UKSC 68. *Medical Law Review*, *23*(4), 668-682. https://doi.org/10.1093/medlaw/fwv027

Neal, M., & Fovargue, S. (2016). Conscience and agent-integrity: A defence of conscience-based exemptions in the healthcare context. *Medical Law Review*, *24*(4), 544-570. https://doi.org/10.1093/medlaw/fww023

Neal, M., & Fovargue, S. (2019). Is conscientious objection incompatible with healthcare professionalism? *The New Bioethics*, *25*(3), 221-235. https://doi.org/10.1080/20502877.2019.1651935

Nejaime, D., & Siegel, R. B. (2015). Conscience wars: Complicity-based conscience claims in religion and politics. *The Yale Law Journal*, *124*(7), 2516-2591. http://www.jstor.org/stable/43617085

Newman, L. (2013). *The compromise of conscience: Conscientious objection in healthcare* [Undergraduate Dissertation, Victoria University of Wellington]. CORE Victoria University of Wellington Repository. https://core.ac.uk/download/pdf/41338696.pdf

NHS. (2020a, April). *Risks: Abortion*. https://www.nhs.uk/conditions/abortion/risks/

NHS. (2020b, April). *What happens: Abortion*. https://www.nhs.uk/conditions/abortion/what-happens/

Nieminen, P., Lappalainen, S., Ristimäki, P., Myllykangas, M., & Mustonen, A.-M. (2015). Opinions on conscientious objection to induced abortion among Finnish medical and nursing students and professionals. *BMC Medical Ethics*, *16*(1), Article 17. https://doi.org/10.1186/s12910-015-0012-1

Nordberg, E., Skirbekk, H., & Magelssen, M. (2014). Conscientious objection to referrals for abortion: Pragmatic solution or threat to women's rights? *BMC Medical Ethics*, *15*(1), Article 15. https://doi.org/10.1186/1472-6939-15-15

Nordstrand, S., Nordstrand, M., Nortvedt, P., & Magelssen, M. (2014). Medical students' attitudes towards conscientious objection: A survey. *Journal of Medical Ethics*, *40*(9), 609-612. https://doi.org/10.1136/medethics-2013-101482

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in Nursing & Health*, *31*(4), 391-398. https://doi.org/10.1002/nur.20259

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*, 1-13. https://doi.org/10.1177/1609406917733847

Nursing and Midwifery Council. (2018). *The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. https://www.nmc.org.uk/standards/code/

O'Connor, R., O'Doherty, J., O'Mahony, M., & Spain, E. (2019). Knowledge and attitudes of Irish GPs towards abortion following its legalisation: A cross-sectional study. *BJGP Open*, *3*(4), bjgpopen19X101669. https://doi.org/10.3399/bjgpopen19X101669

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30-61). Routledge.

Oakley, A. (2016). Interviewing women again: Power, time and the gift. *Sociology*, *50*(1), 195-213. https://doi.org/10.1177/0038038515580253

Oderberg, D. S. (2017). Further clarity on cooperation and morality. *Journal of Medical Ethics*, *43*(4), 192-200. https://doi.org/10.1136/medethics-2016-103476

Offences Against the Person Act, (1861). https://www.legislation.gov.uk/ukpga/Vict/24-25/100/contents

Okin, S. M. (2013). *Women in Western political thought*. Princeton University Press.

Olszynko-Gryn, J. (2019). The feminist appropriation of pregnancy testing in 1970s Britain. *Women's History Review*, *28*(6), 869-894. https://doi.org/10.1080/09612025.2017.1346869

Oltmann, S. (2016). Qualitative interviews: A methodological discussion of the interviewer and respondent contexts. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *17*(2). https://doi.org/10.17169/fqs-17.2.2551

Opdenakker, R. (2006). Advantages and disadvantages of four interview techniques in qualitative research. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *7*(4). https://doi.org/10.17169/fqs-7.4.175

Oppenheim M. (2022, July 8). *Nadine Dorries' call for abortion time limit to be reduced in UK sparks fury*. The Independent. https://www.independent.co.uk/news/uk/politics/nadine-dorries-abortion-time-limit-b2118180.html

Orr, J. (2017). *Abortion wars: The fight for reproductive rights*. Policy Press.

Oxley, J. C. (2011). Liberal feminism. In M. Bruce & S. Barbone (Eds.), *Just the arguments* (1st ed., pp. 258-262). Blackwell Publishing Ltd. https://doi.org/10.1002/9781444344431.ch68

Parliamentary Assembly. (2010). *The right to conscientious objection in lawful medical case: Resolution 1763*. Council of Europe. http://assembly.coe.int/nw/xml/XRef/XrefXML2HTMLen.asp?fileid=17909#:~:text=No%20person%2C%20hospital%20or%20institution,or%20embryo%2C%20for%20any%20reason.

Parliamentlive.tv. (2018, January 26). *Legislation: Conscientious objection (medical activities) Bill [HL] - 2nd reading* https://parliamentlive.tv/Event/Index/ddd57966-d976-48f3-a0f0-0b4336f5c019

Parliament UK. (1999, March 3). *Memorandum from the Abortion Law Reform Association (SR 18): Inquiry into future NHS staffing requirements regarding termination of pregnancy*. https://publications.parliament.uk/pa/cm199899/cmselect/cmhealth/38/38ap62.htm

Parliament UK. (2012, October 31). *Induced abortion.* https://publications.parliament.uk/pa/cm201213/cmhansrd/cm121031/halltext/121031h0001.htm#12103141000308

Parsons, J. A. (2020). 2017–19 Governmental decisions to allow home use of misoprostol for early medical abortion in the UK. *Health Policy*, *124*(7), 679-683. https://doi.org/10.1016/j.healthpol.2020.04.014

Patrick, L. D. (2016). Found poetry: Creating space for imaginative arts-based literacy research writing. *Literacy Research: Theory, Method, and Practice*, *65*(1), 384-403. https://doi.org/10.1177/2381336916661530

Paul, R. A. (2015). *Mixed messages: Cultural and genetic inheritance in the constitution of human society*. University of Chicago Press.

Paxton, P., & Hughes, M. (2007). *Women, politics, and power: A global perspective*. Pine Forge Press.

Pellegrino, E. D. (2002). The physician's conscience, conscience clauses, and religious belief: A Catholic perspective. *Fordham Urban Law Journal*, *30*, 221-244.

Perry, A., & Bigelow, M. G. (2020). The therapeutic nature of qualitative interviewing: Benefits of research participation. *Journal of Research Initiatives*, *5*(2), Article 2. https://digitalcommons.uncfsu.edu/jri/vol5/iss2/2

Phoenix, A. (1994). Practising feminist research: The intersections of gender and 'race' in the research process. In M. Maynard & J. Purvis (Eds.), *Researching women's lives from a feminist perspective* (pp. 201-216). Taylor and Francis.

Piaget, J. (1974). *La prise de conscience.* [The dictates of conscience]. Presses Universitaires de France.

Piirto, J. (2002). The question of quality and qualifications: Writing inferior poems as qualitative research. *International Journal of Qualitative Studies in Education*, *15*(4), 431-445. https://doi.org/10.1080/09518390210145507

Pitman, G. E. (2002). V. outsider/insider: The politics of shifting identities in the research process. *Feminism & Psychology*, *12*(2), 282-288. https://doi.org/10.1177/0959353502012002017

Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: Appraising evidence for nursing practice* (7th ed.). Lippincott Williams & Wilkins, Philadelphia. https://www.philadelphia.edu.jo/nursing/syllabus/940325.pdf

Prendergast, M. (2009). "Poem is what?" Poetic inquiry in qualitative social science research. *International Review of Qualitative Research*, *1*(4), 541-568. https://doi.org/10.1525/irqr.2009.1.4.541

Proudman, C. (2022, August 19). *Think abortion is legal in Great Britain? Ask the two women currently facing life sentences.* The Guardian. https://www.theguardian.com/commentisfree/2022/aug/19/abortion-legal-great-britain-women-life-sentences-roe-v-wade

Purcell, C. (2015). The sociology of women's abortion experiences: Recent research and future directions. *Sociology Compass*, *9*(7), 585-596. https://doi.org/10.1111/soc4.12275

Purcell, C., Cameron, S., Caird, L., Flett, G., Laird, G., Melville, C., & McDaid, L. M. (2014). Access to and experience of later abortion: Accounts from women in Scotland. *Perspectives on Sexual and Reproductive Health*, *46*(2), 101-108. https://doi.org/10.1363/46e1214

Purcell, C., Hilton, S., & McDaid, L. (2014). The stigmatisation of abortion: A qualitative analysis of print media in Great Britain in 2010. *Culture, Health & Sexuality*, *16*(9), 1141-1155. https://doi.org/10.1080/13691058.2014.937463

Rahn, N. (2021). *Funding abortion as facilitating it: The complicity argument in religious right legal efforts to control reproductive choice in the United States* [Undergraduate Honours Theses, Seattle University]. SeattleU scholar works https://scholarworks.seattleu.edu/cgi/viewcontent.cgi?article=1003&=&context=wgst-theses&=&seiredir=1&referer=https%253A%252F%252Fscholar.google.

com%252Fscholar%253Fhl%253Den%2526as_sdt%253D0%25252C5%2526q%253Dtax%252Bpaying%252Band%252Bcomplicity%252Babortion%252B%2526btnG%253D#search=%22tax%20paying%20complicity%20abortion%22

Raifman, S., Hajri, S., Gerdts, C., & Foster, D. (2018). Dualities between Tunisian provider beliefs and actions in abortion care. *Reprod Health Matters*, *26*(52), 47-57. https://doi.org/10.1080/09688080.2018.1472486

Ramsayer, B., & Fleming, V. (2020). Conscience and conscientious objection: The midwife's role in abortion services. *Nursing Ethics*, *27*(8), 1645-1654. https://doi.org/10.1177/0969733020928416

Raymond, E. G., Grossman, D., Wiebe, E., & Winikoff, B. (2015). Reaching women where they are: Eliminating the initial in-person medical abortion visit. *Contraception*, *92*(3), 190-193. https://doi.org/10.1016/j.contraception.2015.06.020

Rebouché, R. (2016). Abortion rights as human rights. *Social & Legal Studies*, *25*(6), 765-782. https://doi.org/10.1177/0964663916668391

Regan, L., & Glasier, A. (2017). The British 1967 Abortion Act-still fit for purpose? *Lancet*, *390*(10106), 1936-1937. https://doi.org/10.1016/S0140-6736(17)32753-8

Reichlin, M. (2022). The reasonableness standard for conscientious objection in healthcare. *Journal of Bioethical Inquiry*, *19*(2), 255-264. https://doi.org/10.1007/s11673-021-10165-5

Reproductive Health (Access to Terminations) Bill, (2017). https://bills.parliament.uk/bills/1971

Rhodes, R. (2006). The ethical standard of care. *The American Journal of Bioethics*, *6*(2), 76-78. https://doi.org/10.1080/15265160500507074

Richards, N. K., Masud, A., & Arocha, J. (2020). P28 Breaking down abortion barriers: Reddit users' empowerment in absence of parental and medical support. *Contraception*, *102*(4), 286-286. https://doi.org/10.1016/j.contraception.2020.07.047

Richardson, L. (1994). Nine poems: Marriage and the family. *Journal of Contemporary Ethnography*, *23*(1), 3-13. https://doi.org/10.1177/089124194023001001

Rioux, C., Weedon, S., London-Nadeau, K., Paré, A., Juster, R.-P., Roos, L. E., Freeman. M., Tomfohr-Madsen, L. M. (2021). Gender-inclusive writing for epidemiological research on pregnancy. *Journal of Epidemiology and Community Health*. *76*(9), 823-827. https://doi.org/10.31235/osf.io/csnqw

Ripley, E. (2006). A review of paying research participants: It's time to move beyond the ethical debate. *Journal of Empirical Research on Human Research Ethics*, *1*(4), 9-20. https://doi.org/10.1525/jer.2006.1.4.9

Rocca, C., Kimport, K., Roberts, S., Gould, H., Neuhaus, J., & Foster, D. (2015). Decision rightness and emotional responses to abortion in the United States: A longitudinal study. *PLoS One*, *10*(7), e0128832. https://doi.org/10.1371/journal.pone.0128832

Rodger, D., & Blackshaw, B. P. (2020). Quotas: Enabling conscientious objection to coexist with abortion access. *Health Care Analysis*, *29*, 154-169. https://doi.org/10.1007/s10728-020-00419-5

Rogers-Shaw, C. (2021). Enhancing empathy and understanding of disability by using poetry in research. *Studies in the Education of Adults*, *53*(2), 184-203. https://doi.org/10.1080/02660830.2021.1920740

Rossetto, K. R. (2014). Qualitative research interviews: Assessing the therapeutic value and challenges. *Journal of Social and Personal Relationships*, *31*(4), 482-489. https://doi.org/10.1177/0265407514522892

Rough, E. (2023, February 6). *Abortion in Northern Ireland: Recent changes to the legal framework*. UK Parliament, House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/cbp-8909/

Rowley, J. (2002). Using case studies in research. *Management Research News*, *25*(1), 16-27. https://doi.org/10.1108/01409170210782990

Royal College of Nursing. (2020). *RCN guidance conscientious objection (termination of pregnancy)*. https://www.rcn.org.uk/Professional-Development/publications/rcn-guidance-termination-of-pregnancy-uk-pub-009325

Rubin, L., & Russo, N. (2004). Abortion and mental health: What therapists need to know. *Women & Therapy*, *27*(3-4), 69-90. https://doi.org/10.1300/J015v27n03_06

Savulescu, J. (2006). Conscientious objection in medicine. *BMJ*, *332*(7536), 294-297. https://doi.org/10.1136/bmj.332.7536.294

Savulescu, J., & Schuklenk, U. (2017). Doctors have no right to refuse medical assistance in dying, abortion or contraception. *Bioethics*, *31*(3), 162-170. https://doi.org/10.1111/bioe.12288

Schuklenk, U. (2015). Conscientious objection in medicine: Private ideological convictions must not supersede public service obligations. *Bioethics*, *29*(5), ii–iii. https://doi.org/10.1111/bioe.12167

Schuklenk, U. (2016). Accommodating conscientious objection in medicine-private ideological convictions must not trump professional obligations. *The Journal of Clinical Ethics*, *27*(3), 227-232. http://europepmc.org/abstract/MED/27658278

Schuklenk, U. (2018). Conscientious objection in medicine: Accommodation versus professionalism and the public good. *British Medical Bulletin*, *126*(1), 47-56. https://doi.org/10.1093/bmb/ldy007

Schuklenk, U., & Smalling, R. (2017). Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies. *Journal of Medical Ethics*, *43*(4), 234-240. https://doi.org/10.1136/medethics-2016-103560

Scottish Government. (2022). Early medical abortion at home. https://www.gov.scot/news/early-medical-abortion-at-home-1/

Seitz, S. (2016). Pixilated partnerships, overcoming obstacles in qualitative interviews via Skype: A research note. *Qualitative Research*, *16*(2), 229-235. https://doi.org/10.1177/1468794115577011

Self, B. (2021). Conducting interviews during the COVID-19 pandemic and beyond. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, *22*(3), https://doi.org/10.17169/fqs-22.3.3741

Sepper, E. (2012). Taking conscience seriously. *Virginia Law Review*, *98*(7), 1501-1575. http://dx.doi.org/10.2139/ssrn.1888375

Sexual Health Policy Team. (2014). *Guidance in relation to requirements of the Abortion Act 1967*. Department of Health. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/313459/20140509_-_Abortion_Guidance_Document.pdf

Shahvisi, A. (2018). Conscientious objection: A morally insupportable misuse of authority. *Clinical Ethics*, *13*(2), 82-87. https://doi.org/10.1177/1477750917749945

Shaw, J. (2018). Conscientious affirmations: A response to conscientious objections to abortion. *Women's Reproductive Health*, *5*(4), 277-286. https://doi.org/10.1080/23293691.2018.1523120

Sheldon, S. (2016). The decriminalisation of abortion: An argument for modernisation. *Oxford Journal of Legal Studies*, *36*(2), 334-365. https://doi.org/10.1093/ojls/gqv026

Sifris, R., & Penovic, T. (2021). Barriers to abortion access in Australia before and during the COVID-19 pandemic. *Women's Studies International Forum*, *86*, Article 102470. https://doi.org/10.1016/j.wsif.2021.102470

SimpleGP. (2019, November 23). Guidance on conscientious objection to abortion for healthcare workers in Northern Ireland. *Simple GP*. https://simplegp.net/2019/11/23/guidance-on-conscientious-objection-to-abortion-for-healthcare-workers-in-northern-ireland/

Sjollema, S. D., Hordyk, S., Walsh, C. A., Hanley, J., & Ives, N. (2012). Found poetry – Finding home: A qualitative study of homeless immigrant women. *Journal of Poetry Therapy*, *25*(4), 205-217. https://doi.org/10.1080/08893675.2012.736180

Skinner, B. F. (1971). *Beyond freedom and dignity* (1st ed.). Alfred A. Knopf.

Smetana, J. G. (1997). Parenting and the development of social knowledge reconceptualized: A social domain analysis. In J. E Grusec & L. Kuczynski (Eds.), *Parenting and children's internalization of values: A handbook of contemporary theory* (pp. 162-192). John Wiley & Sons Inc.

Smith, S. W. (2018). Individualised claims of conscience, clinical judgement and best interests. *Health Care Analysis*, *26*(1), 81-93. https://doi.org/10.1007/s10728-016-0330-6

Soengas, A. M., & Ramos, A. C. (2020). Perception of medical students in Galicia (Spain) regarding conscientious objection to the voluntary termination of pregnancy. *Gaceta Sanitaria*, *34*(2), 150-156. https://doi.org/10.1016/j.gaceta.2019.02.007

St John & St Elizabeth Hospital. (n.d.). *We are a private hospital at the heart of the London community*. https://hje.org.uk/?gclid=CjwKCAiAjPyfBhBMEiwAB2CCIo7sFH3Mo8m9aa1sk0-8z6O5RY5GaV1i3aEK9ll9m2gIWLf0dWMklhoC_4UQAvD_BwE

Stopler, G. (2005). The liberal bind: The conflict between women's rights and patriarchal religion in the liberal state. *Social Theory and Practice*, *31*(2), 191-231. https://doi.org/10.5840/soctheorpract20053129

Strickland, S. L. (2012). Conscientious objection in medical students: A questionnaire survey. *Journal of Medical Ethics*, *38*(1), 22-25. https://doi.org/10.1136/jme.2011.042770

Stulberg, D. B., Dude, A. M., Dahlquist, I., & Curlin, F. A. (2012). Obstetrician-gynecologists, religious institutions, and conflicts regarding patient-care policies. *American Journal of Obstetrics and Gynecology*, *207*(1), 73.el-73.e5. https://doi.org/10.1016/j.ajog.2012.04.023

Sturges, J., & Hanrahan, K. (2004). Comparing telephone and face-to-face qualitative interviewing: A research note. *Qualitative Research*, *4*(1), 107-118. https://doi.org/10.1177/1468794104041110

Suk, J. (2010). The trajectory of trauma: Bodies and minds of abortion discourse. *Columbia Law Review*, *110*(5), 1193-1252. http://www.jstor.org/stable/27806649

Sulmasy, D. P. (2008). What is conscience and why is respect for it so important? *Theoretical Medicine and Bioethics*, *29*(3), 135-149. https://doi.org/10.1007/s11017-008-9072-2

Sweet, L. (2002). Telephone interviewing: Is it compatible with interpretive phenomenological research? *Contemporary Nurse*, *12*(1), 58-63. https://doi.org/10.5172/conu.12.1.58

Tang, N. (2002). Interviewer and interviewee relationships between women. *Sociology*, *36*(3), 703-721. https://doi.org/10.1177/0038038502036003011

Targum, S. D. (2011). The distinction between clinical and research interviews in psychiatry. *Innovations in Clinical Neuroscience*, *8*(3), 40-44.

Taylor, D., Postlethwaite, D., Desai, S., James, E. A., Calhoun, A. W., Sheehan, K., & Weitz, T. A. (2013). Multiple determinants of the abortion care experience: From the patient's perspective. *American Journal of Medical Quality*, *28*(6), 510-518. https://doi.org/10.1177/1062860613484295

The Abortion (Northern Ireland) Regulations. (2022). https://www.legislation.gov.uk/uksi/2022/554/made

The Royal College of Midwives. (2016). *Position statement abortion* https://www.rcm.org.uk/media/2296/abortion-statement.pdf

The Royal College of Obstetricians and Gynaecologists. (2022). *National service specification for NHS abortion care - 2022*. https://www.rcog.org.uk/media/ujmfhg0h/national-service-specification-for-abortion-care-nov-2022.pdf

Thomas, T. (2023, June 12). *Outrage at jail sentence for woman who took abortion pills later than UK limit*. The Guardian. https://www.theguardian.com/world/2023/jun/12/woman-in-uk-jailed-for-28-months-over-taking-abortion-pills-after-legal-time-limit

Thompson, R. A. (2014). Conscience development in early childhood. In M. Killen & J. G. Smetana (Eds.), *Handbook of moral development* (pp. 73-92). Psychology Press. https://doi.org/10.4324/9780203581957.ch4

Tilles, C., Denny, A., Cansino, C., & Creinin, M. D. (2016). Factors influencing women's satisfaction with surgical abortion. *Contraception*, *93*(2), 164-169. https://doi.org/10.1016/j.contraception.2015.09.012

Tongue, Z. L. (2022). On conscientious objection to abortion: Questioning mandatory referral as compromise in the international human rights framework. *Medical Law International*, *22*(4), 09685332221119503. https://doi.org/10.1177/09685332221119503

Toro-Flores, R., Bravo-Agüi, P., Catalán-Gómez, M. V., González-Hernando, M., Guijarro-Cenisergue, M. J., Moreno-Vázquez, M. V., Roch-Hamelin. I., Velasco-Sanz, T. R. (2019). Opinions of nurses regarding conscientious objection. *Nursing Ethics*, *26*(4), 1027-1038. https://doi.org/10.1177/0969733017731915

Trigg, R. (2017). Conscientious objection and 'effective Referral'. *Cambridge Quarterly of Healthcare Ethics*, *26*(1), 32-43. https://doi.org/10.1017/S0963180116000633

Turiel, E. (2002). *The culture of morality: Social development, context, and conflict*. Cambridge University Press.

UN Human Rights Treaty Bodies. (2016). UN Treaty Body database: CCPR/C/116/D/2324/2013. In: Office of the United Nations High Commissioner for Human Rights.

UNISON. (2022). *UNISON backs abortion rights and decriminalisation*. https://www.unison.org.uk/news/article/2022/07/unison-backs-abortion-rights-and-decriminalisation/

United Nations. (1948). Universal Declaration of Human Rights. https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

United Nations. (1966). International Covenant on Civil and Political Rights. https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx

Velez, A. C. G., & Urbano, L. G. (2016). Improper use of conscientious objection to abortion. *International Perspectives on Sexual and Reproductive Health*, *42*(4), 221-222. https://doi.org/10.1363/intsexrephea.42.4.221

Viggiani, G. (2019). Bandi per medici non obiettori. Spunti per una riflessione su aborto e libertà di scelta [Calls for non-conscientious doctors. Ideas for a reflection on the abortion and the freedom of choice]. *Biolaw Journal-Rivista Di Biodiritto* (2), 315-327.

Vishnevsky, T., & Beanlands, H. (2004). Qualitative research. *Nephrology Nursing Journal*, *31*(2), 234-238.

Wakley, G. (2007). Legal interpretation of the Abortion Act 1967: The role of nurses in surgical induced abortion. *Journal of Family Planning and Reproductive Health Care*, *33*(2), 77-78. https://srh.bmj.com/content/familyplanning/33/2/77.full.pdf

Weitz, T. A., & Cockrill, K. (2010). Abortion clinic patients' opinions about obtaining abortions from general women's health care providers. *Patient Education and Counselling*, *81*(3), 409-414. https://doi.org/10.1016/j.pec.2010.09.003

Wester, G. (2015). Conscientious objection by health care professionals. *Philosophy Compass*, *10*(7), 427-437. https://doi.org/10.1111/phc3.12235

Whale, K. (2017). The use of Skype and telephone interviews in sensitive qualitative research with young people: Experiences from the ROCCA continence study. *Qual Methods Psychol Bull*, *23*. https://shop.bps.org.uk/publications/

publications-by-subject/qualitative- methods/qmip-bulletin-issue-23-spring-2017.html

Whitehouse, K. C., Blaylock, R., Makleff, S., & Lohr, P. A. (2021). It's a small bit of advice, but actually on the day, made such a difference…: Perceptions of quality in abortion care in England and Wales. *Reproductive Health*, *18*(1), Article 221. https://doi.org/10.1186/s12978-021-01270-0

Whitson, R. (2017). Painting pictures of ourselves: Researcher subjectivity in the practice of feminist reflexivity. *The Professional Geographer*, *69*(2), 299-306. https://doi.org/10.1080/00330124.2016.1208510

Wicclair, M. R. (2011). *Conscientious objection in health care: An ethical analysis*. Cambridge University Press.

Wicclair, M. R. (2009). Negative and positive claims of conscience special section. *Cambridge Quarterly of Healthcare Ethics*, *18*(1), 14-22. https://doi.org/10.1017/S096318010809004X

Wicclair, M. R. (2019). Preventing conscientious objection in medicine from running amok: a defence of reasonable accommodation. *Theoretical Medicine and Bioethics*, *40*(6), 539-564. https://doi.org/10.1007/s11017-019-09514-8

Widodo, H. P. (2014). Methodological considerations in interview data transcription. *International Journal of Innovation in English Language Teaching and Research*, *3*(1), 101-107.

Wiebe, E. R., & Sandhu, S. (2008). Access to abortion: What women want from abortion services. *Journal of Obstetrics and Gynaecology Canada*, *30*(4), 327-331. https://doi.org/10.1016/S1701-2163(16)32801-8

Wiggins, J. (2011). Feeling it is how I understand it: Found poetry as analysis. *International Journal of Education & the Arts*, *12*(3), 1-18. http://www.ijea.org/v12lai3/

Women on Waves Group. (n.d.). *Warning, fake abortion pills for sale online!!* https://www.womenonwaves.org/en/page/974/warning-fake-abortion-pills-for-sale-online

World Health Organization. (2015). *Health worker roles in providing safe abortion care and post-abortion contraception: Executive summary*. https://apps.who.int/iris/handle/10665/181043

World Health Organization. (2022). *Abortion Care Guideline*. https://www.who.int/publications/i/item/9789240039483.

Wright, T. (2018). Beauty in the struggle: Poetry found in the lives of mothers experiencing homelessness. *Anthropology & Education Quarterly*, *49*(4), 462-468. https://doi.org/10.1111/aeq.12262

Yazan, B. (2015). Three approaches to case study methods in education: Yin, Merriam, and Stake. *The Qualitative Report*, *20*(2), 134-152. http://nsuworks.nova.edu/tqr/vol20/iss2/12

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). SAGE Publications, Inc.

Zampas, C. (2013). Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings. *International Journal of Gynecology & Obstetrics*, *123*(Suppl. 3), S63-S65. https://doi.org/10.1016/S0020-7292(13)60005-3

Zampas, C., & Gher, J. (2008). Abortion as a human right—international and regional standards. *Human Rights Law Review*, *8*(2), 249-294.

Zareba, K., Ciebiera, M., Gierus, J., & Jakiel, G. (2019). Perceptions of attending medical staff by women accessing pregnancy termination in Poland: A qualitative study. *The European Journal of Contraception and Reproductive Health Care*, *24*(2), 124-129. https://doi.org/10.1080/13625187.2019.1590698

Appendix A Interview Guide

Interviews with service users regarding HCPs (Health care professionals) CO (Conscientious objection).

Section one: About you

You do not have to disclose this information if you don't wish to.

Please could you tell me about your…

1. **Ethnicity?**
2. **How you identify in terms of gender?**
3. **Religion/non? How you practice your religion?**
4. **Age?**
5. **Occupation?**
6. **Social class?**
7. **Geographic location?**

Section two: Understanding of CO.

1. **Do you know about the conscientious objection clause in the 1967 Abortion Act? If yes, what do you know? (If no explain using quote * and skip to section 3)**

   Prompts- How do you know about this? When- before/after abortion?

***Definition of CO for ALL participants:**

'The refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, personal, or ethical beliefs'

Section three: Experiences.

1. **Please tell me about your abortion journey in as little or as much detail as you would like. Feel free to stop at any time.**
   Prompt- Age? Number of abortions?, location?, what stage of the pregnancy?, what type of abortion?

2. **Have you - or do you know someone - who has experienced an HCP CO to abortion?**
   Prompt- Who objected? On what grounds? (If known)

   If yes:

3. **How did this impact you/them?**
   Prompt- time? Emotion? How did/does this make you feel? Financial element? Did this change your relationship with the HCP? How?

4. **When the HCP CO what happened next?**
   Prompt- quick? Referral process?

   Yes and No:

1. **Did you feel supported by staff?**
   Prompt- in your decision, even if staff objected. Who did support you if not staff.

Section four: Opinions of CO.

1. **Do you think that healthcare practitioners should have the right to object to participating in abortion?**

Prompt- In what circumstances, why? Which HCP (GP, Midwives, Pharmacists?) How does the right of the patient impact this?

2. **There are three main perspectives in the literature. 1. No CO, if you enter the health service you should take on any tasks. 2. You can CO to anything- may be letter writing or scheduling abortions. 3. Middle-ground- you can CO so long as you refer the patient and inform them – excluding emergencies.**

what do you think of these?

3. **In some countries like Italy and America, you'll have whole institutions objecting, for example Catholic hospitals, the hospital as a whole won't provide abortion services.**
   What do you think about that happening?
   Prompt- Italy 70%-90%

4. **Should CO be regulated? How?**
   Prompt- who should be responsible: NHS, independent body, HCPs?

<u>Section five: Opinions on participation.</u>

1. **In the law it states that you don't have to participate in abortion. What would you see as participating in abortion?**
   Prompt- hands on action? What exactly is this? Where should the line be drawn? Administration roles? Doogan and Wood case as prompt

2. **It's been debated. What participation is 'because there was a massive case where two midwives- they've been working for 20 years and never had to deal with abortion, because they had a conscientious objection, so they did not have to. There was a restructuring in the service, which meant they would have to supervise others who'd be performing abortions. They**

basically have to make phone calls, schedule staff in on the rotas, so admin and supervisory based, no hands-on participation. They did not want to do this because of CO. Do you think you should be able to object in that case?

that case actually ended with the supreme court saying participation is hands on care only. So, they weren't able to object for these reasons. So, we have a problem now with how we should actually define participation.

3. **What elements of the abortion process should HCP be allowed to refrain from?**
   Break down to –GP's, Midwives and explain roles.
4. **Earlier we talked about referral to another HCP. Do you think this is participation in abortion?**

---

5. **If a GP refused to provide you with an abortion, how would this make you feel? What would you do next?**
   Prompt- question own moral stance? How do/es your personality/personal experiences impact upon your answer?

Section six: reflexive element.

1. **How do you think your experiences have impacted your opinion of HCP CO, and how you answered the previous questions (section 4-5)?**
   Prompt- Have your opinions changed during your abortion journey? How? Pre experiencing CO-post experiencing Co (if relevant).

Section seven:

1. **Is there anything you would like to add?**
2. **Is there anything you would like to ask me?**

Appendix B Participant Recruitment Material

Research Study: *Service Users' Understandings and Experiences of Health Care Practitioners' Right to Conscientious Objection to Abortion.*

Have you had an abortion in the UK? Are you over 18?*

Do you wish to have your say, share your experiences, and contribute to research that has the potential to inform abortion policy and guidelines?

If you would like to participate in a confidential interview over the phone, via skype or at a location of you choosing (in Liverpool) please get in touch.

LIVERPOOL JOHN MOORES UNIVERSITY

For more information, or to get in touch please contact the Principal Investigator, Becky Self MSc, BA(Hons):

B.Self@2019.ljmu.ac.uk

[redacted]

*You are unable to take part in this research if you abuse drug/alcohol, have a severe mental health issue, or if you are likely to experience emotional distress when talking about abortion.

Appendix C Participant Recruitment Material

Should Health Care Practitioners (Physicians, Nurses, Midwives etc.) Have the Right to Object to Participating in Abortion?

Who: We want you to have your say if you have had an abortion/termination for fetal anomaly for medical reasons in the UK, and are over the age of 18*.

What: We will be running one-on-one confidential interviews over the phone and via Skype or Zoom. We are interested in your experience of abortion/termination for fetal anomaly for medical reasons, and opinions on objecting Health Care Practitioners.

When: Interviews will be organised over email between you and the researcher at a time that suits you.

Why: Findings will have the potential to inform abortion policy and guidelines.

How: Please get in touch via the 'contact us' page on our website https://www.coabortionexperience.com/contact-us

*You are unable to take part in this research if you abuse drugs/alcohol, have a severe mental health issue, or if you are likely to experience severe emotional distress when talking about abortion/termination for fetal anomaly for medical reasons.

For more information, or to get in touch please contact Becky Self, BA(Hons), MSc.

B.Self@2019.ljmu.ac.uk

Or visit

www.coabortionexperience.com

Appendix D Participant Recruitment Material

ACCESSED ABORTION IN THE UK*?

How do you feel that your healthcare team could have refused to participate?

Want to contribute to research that has the potential to inform policy and guidelines, whilst being compensated for your time?

We are interested in your experiences of abortion, and opinions on health care practitioners' right to object to participating in abortion (no prior knowledge necessary).

We will be running one-on-one confidential interviews online and over the phone. Interviews will last between 30-60 minutes.

Please get in touch via the ‘contact us’ page on our website https://www.coabortionexperience.com

You will be compensated £30** for your time.

*You are able to take part in this research if you are over the age of 18. You are unable to take part if you abuse drugs/alcohol, have a severe mental health condition, or if you are likely to experience severe emotional distress when talking about abortion.
**£30 love2shop gift voucher.

LIVERPOOL
JOHN MOORES
UNIVERSITY

Appendix E Participant Recruitment Material

TRIED TO ACCESS/ACCESSED ABORTION IN NI*?

How do you feel that your health care team could have refused/refused to participate?

Want to contribute to research that has the potential to inform policy and guidelines, whilst being compensated for your time?

We are interested in your experiences of abortion, and opinions on health care practitioners' right to object to participating in abortion (no prior knowledge necessary).

We will be running one-on-one confidential interviews online and over the phone. Interviews will last between 30-60 minutes.

Please get in touch via the 'contact us' page on our website https://www.coabortionexperience.com

You will be compensated £30** for your time.

*You are able to take part in this research if you are over the age of 18. You are unable to take part if you abuse drugs/alcohol, have a severe mental health condition, or if you are likely to experience severe emotional distress when talking about abortion.
**£30 love2shop gift voucher.

LIVERPOOL JOHN MOORES UNIVERSITY

Appendix F Participant Recruitment Material

TRIED TO ACCESS/ACCESSED ABORTION IN THE UK*?

Did a health care professional (Dr, Nurse, Midwife etc.) refuse to refer you/participate?

Want to contribute to research that has the potential to inform policy and guidelines, whilst being compensated for your time?

We are interested in your experiences of a health care professional refusing to refuse you/participate in your abortion, and your opinions on their refusal.

We will be running one-on-one confidential interviews online and over the phone. Interviews will last between 30-60 minutes.

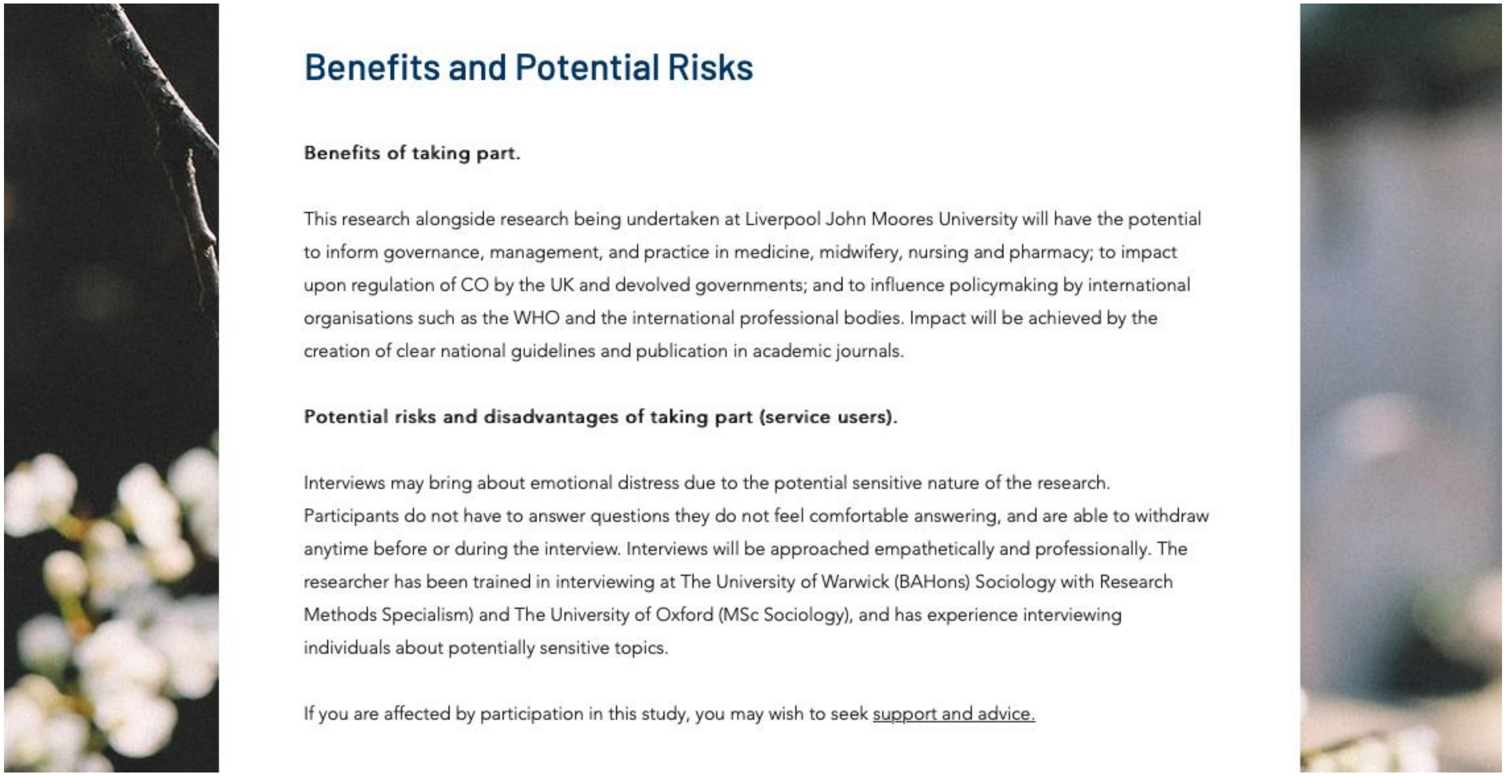
Please get in touch via the ‘contact us’ page on our website https://www.coabortionexperience.com

You will be compensated £30** for your time.

*You are able to take part in this research if you are over the age of 18. You are unable to take part if you abuse drugs/alcohol, have a severe mental health condition, or if you are likely to experience severe emotional distress when talking about abortion.
**£30 love2shop gift voucher.

LIVERPOOL JOHN MOORES UNIVERSITY

Appendix G Screenshot of Excerpt of Participant Information Website



Benefits and Potential Risks

Benefits of taking part.

This research alongside research being undertaken at Liverpool John Moores University will have the potential to inform governance, management, and practice in medicine, midwifery, nursing and pharmacy; to impact upon regulation of CO by the UK and devolved governments; and to influence policymaking by international organisations such as the WHO and the international professional bodies. Impact will be achieved by the creation of clear national guidelines and publication in academic journals.

Potential risks and disadvantages of taking part (service users).

Interviews may bring about emotional distress due to the potential sensitive nature of the research. Participants do not have to answer questions they do not feel comfortable answering, and are able to withdraw anytime before or during the interview. Interviews will be approached empathetically and professionally. The researcher has been trained in interviewing at The University of Warwick (BAHons) Sociology with Research Methods Specialism) and The University of Oxford (MSc Sociology), and has experience interviewing individuals about potentially sensitive topics.

If you are affected by participation in this study, you may wish to seek support and advice.

Appendix H Screenshot of Participant Consent Form

Participant Consent

Please contact us if you wish to take part before completing the participant consent.

Please read all of the information provided on this site before submitting the form below.

By submitting the form below you are agreeing to the following statements:

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, and I am free to remove my data until it has been analysed, 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.

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.

Appendix I Participant Demographic Information Form

Name

Email

I agree to the above statements.

Age

Gender Identity

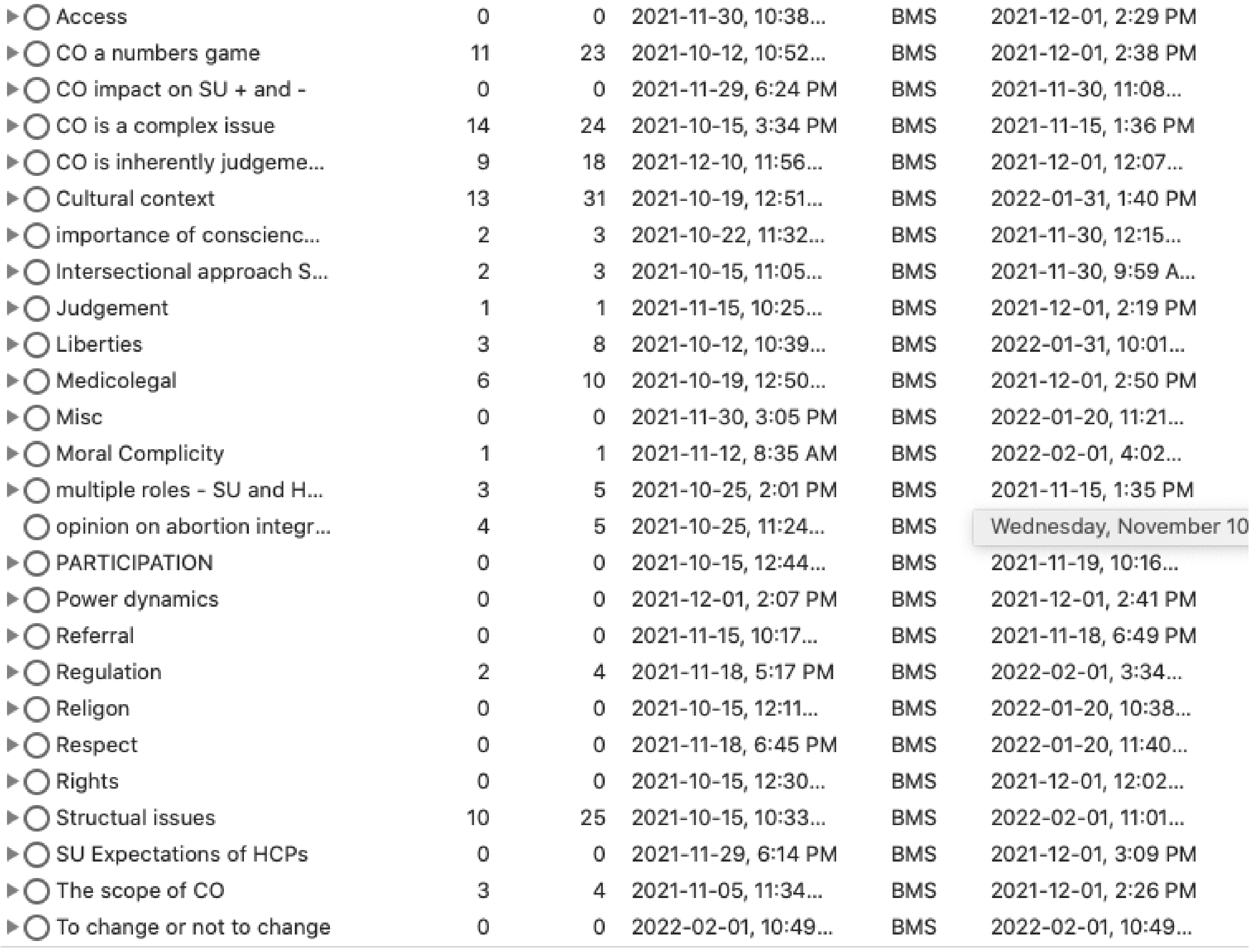
Religion/Non-Religious

Occupation

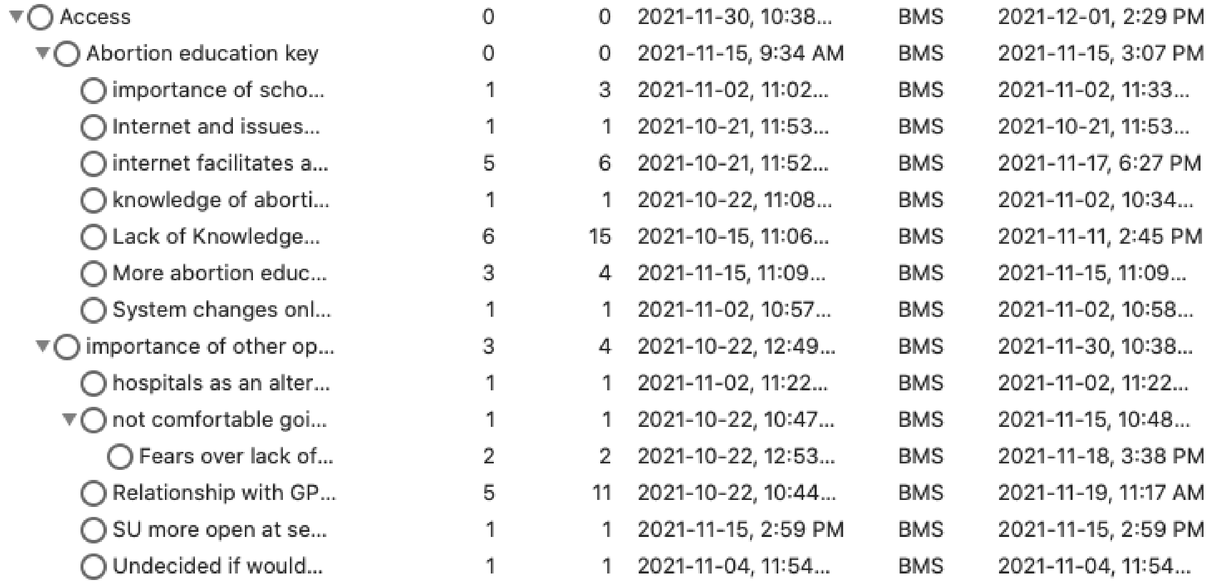
Location

Ethnicity

Appendix J Screenshot of an Example of Coding

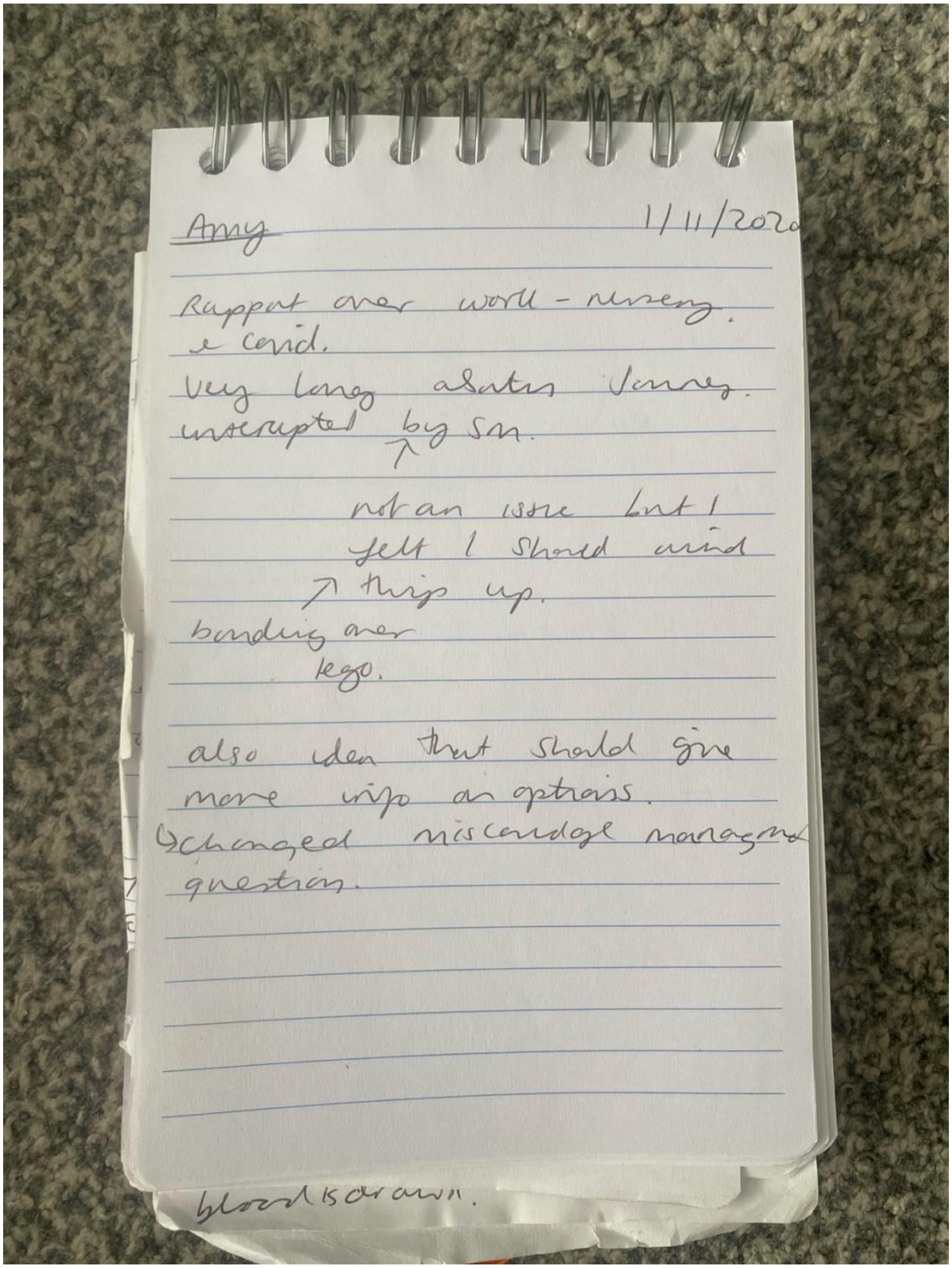


▶ ○ Access	0	0	2021-11-30, 10:38...	BMS	2021-12-01, 2:29 PM
▶ ○ CO a numbers game	11	23	2021-10-12, 10:52...	BMS	2021-12-01, 2:38 PM
▶ ○ CO impact on SU + and -	0	0	2021-11-29, 6:24 PM	BMS	2021-11-30, 11:08...
▶ ○ CO is a complex issue	14	24	2021-10-15, 3:34 PM	BMS	2021-11-15, 1:36 PM
▶ ○ CO is inherently judgeme...	9	18	2021-12-10, 11:56...	BMS	2021-12-01, 12:07...
▶ ○ Cultural context	13	31	2021-10-19, 12:51...	BMS	2022-01-31, 1:40 PM
▶ ○ importance of conscienc...	2	3	2021-10-22, 11:32...	BMS	2021-11-30, 12:15...
▶ ○ Intersectional approach S...	2	3	2021-10-15, 11:05...	BMS	2021-11-30, 9:59 A...
▶ ○ Judgement	1	1	2021-11-15, 10:25...	BMS	2021-12-01, 2:19 PM
▶ ○ Liberties	3	8	2021-10-12, 10:39...	BMS	2022-01-31, 10:01...
▶ ○ Medicolegal	6	10	2021-10-19, 12:50...	BMS	2021-12-01, 2:50 PM
▶ ○ Misc	0	0	2021-11-30, 3:05 PM	BMS	2022-01-20, 11:21...
▶ ○ Moral Complicity	1	1	2021-11-12, 8:35 AM	BMS	2022-02-01, 4:02...
▶ ○ multiple roles - SU and H...	3	5	2021-10-25, 2:01 PM	BMS	2021-11-15, 1:35 PM
○ opinion on abortion integr...	4	5	2021-10-25, 11:24...	BMS	Wednesday, November 10
▶ ○ PARTICIPATION	0	0	2021-10-15, 12:44...	BMS	2021-11-19, 10:16...
▶ ○ Power dynamics	0	0	2021-12-01, 2:07 PM	BMS	2021-12-01, 2:41 PM
▶ ○ Referral	0	0	2021-11-15, 10:17...	BMS	2021-11-18, 6:49 PM
▶ ○ Regulation	2	4	2021-11-18, 5:17 PM	BMS	2022-02-01, 3:34...
▶ ○ Religon	0	0	2021-10-15, 12:11...	BMS	2022-01-20, 10:38...
▶ ○ Respect	0	0	2021-11-18, 6:45 PM	BMS	2022-01-20, 11:40...
▶ ○ Rights	0	0	2021-10-15, 12:30...	BMS	2021-12-01, 12:02...
▶ ○ Structual issues	10	25	2021-10-15, 10:33...	BMS	2022-02-01, 11:01...
▶ ○ SU Expectations of HCPs	0	0	2021-11-29, 6:14 PM	BMS	2021-12-01, 3:09 PM
▶ ○ The scope of CO	3	4	2021-11-05, 11:34...	BMS	2021-12-01, 2:26 PM
▶ ○ To change or not to change	0	0	2022-02-01, 10:49...	BMS	2022-02-01, 10:49...



▼ ○ Access	0	0	2021-11-30, 10:38...	BMS	2021-12-01, 2:29 PM
▼ ○ Abortion education key	0	0	2021-11-15, 9:34 AM	BMS	2021-11-15, 3:07 PM
○ importance of scho...	1	3	2021-11-02, 11:02...	BMS	2021-11-02, 11:33...
○ Internet and issues...	1	1	2021-10-21, 11:53...	BMS	2021-10-21, 11:53...
○ internet facilitates a...	5	6	2021-10-21, 11:52...	BMS	2021-11-17, 6:27 PM
○ knowledge of aborti...	1	1	2021-10-22, 11:08...	BMS	2021-11-02, 10:34...
○ Lack of Knowledge...	6	15	2021-10-15, 11:06...	BMS	2021-11-11, 2:45 PM
○ More abortion educ...	3	4	2021-11-15, 11:09...	BMS	2021-11-15, 11:09...
○ System changes onl...	1	1	2021-11-02, 10:57...	BMS	2021-11-02, 10:58...
▼ ○ importance of other op...	3	4	2021-10-22, 12:49...	BMS	2021-11-30, 10:38...
○ hospitals as an alter...	1	1	2021-11-02, 11:22...	BMS	2021-11-02, 11:22...
▼ ○ not comfortable goi...	1	1	2021-10-22, 10:47...	BMS	2021-11-15, 10:48...
○ Fears over lack of...	2	2	2021-10-22, 12:53...	BMS	2021-11-18, 3:38 PM
○ Relationship with GP...	5	11	2021-10-22, 10:44...	BMS	2021-11-19, 11:17 AM
○ SU more open at se...	1	1	2021-11-15, 2:59 PM	BMS	2021-11-15, 2:59 PM
○ Undecided if would...	1	1	2021-11-04, 11:54...	BMS	2021-11-04, 11:54...

Appendix K Excerpts from Reflexive Diary



Amy 1/11/2020

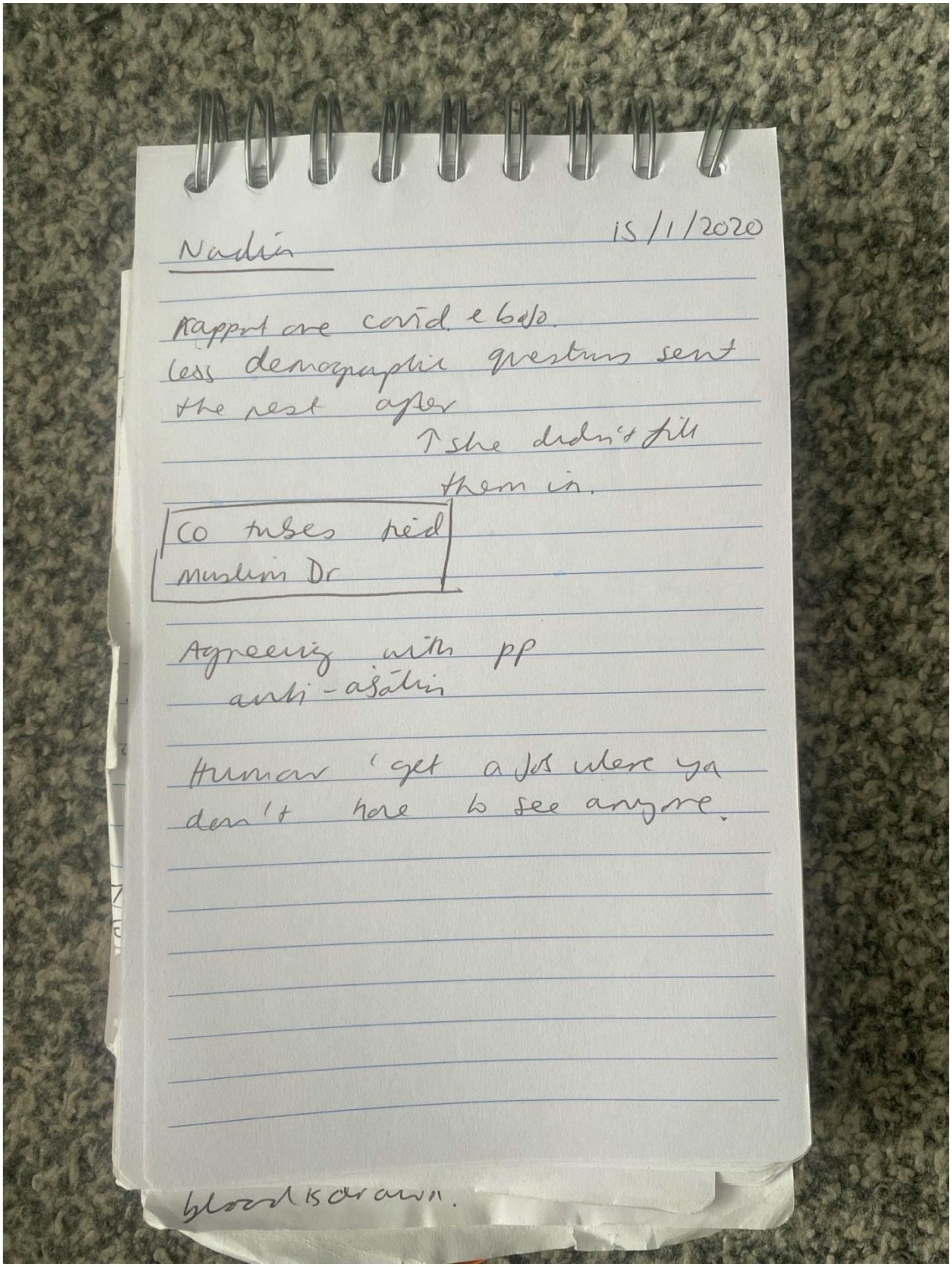
Rapport over work - nursery.
& covid.
Very long about journey.
interrupted by son.

not an issue but I
felt I should wind
things up.

bonding over
lego.

also idea that should give
more info on options.
↳ changed miscarriage management
question.

blood is drawn.



Nadia

15/1/2020

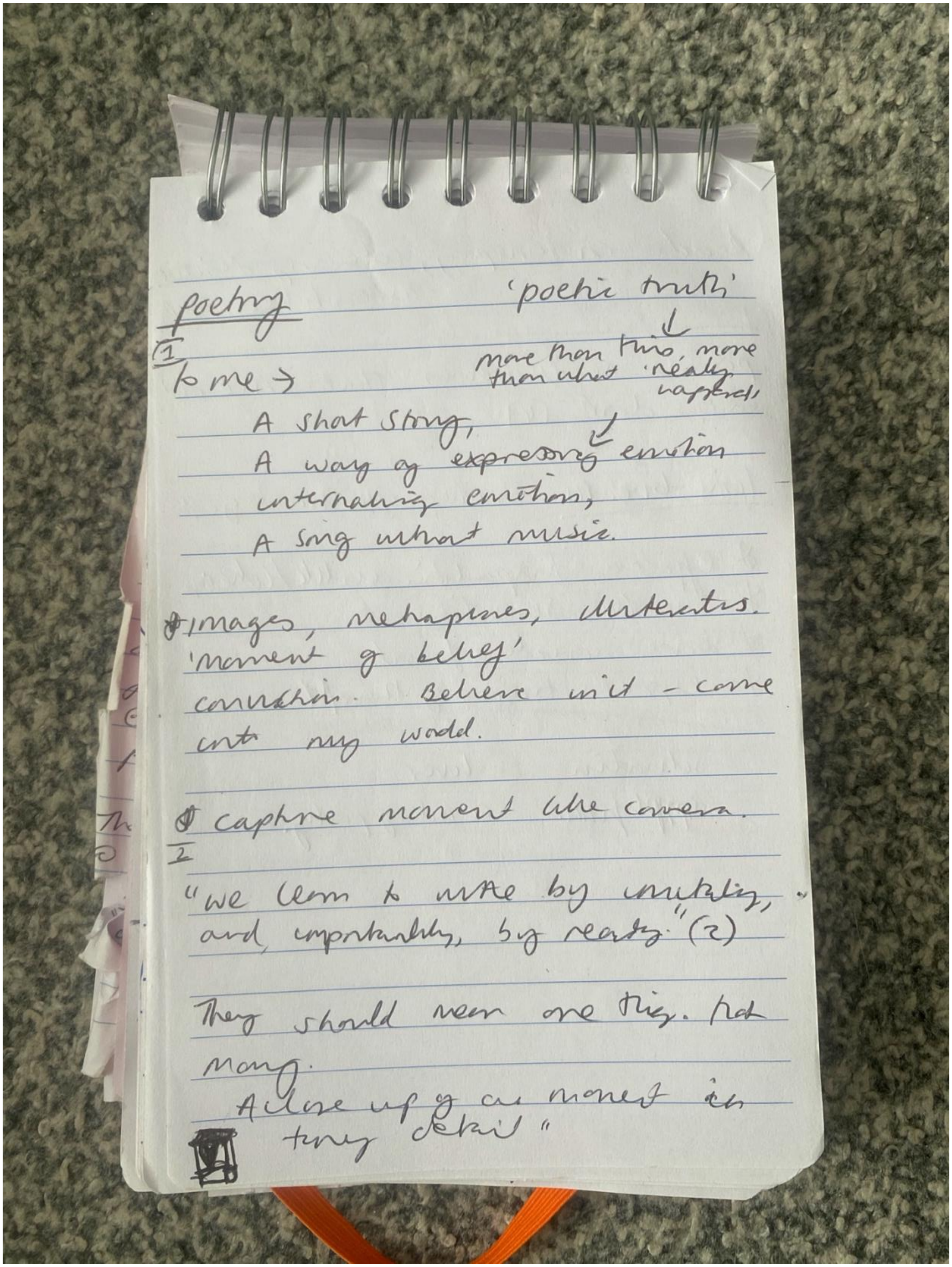
Rapport ove covid e bdo.
Less demographic questions sent
the rest after
↑ she didn't fill
them in.

CO tubes red
Muslim Dr

Agreeing with pp
anti-abortion

Humour 'get a job where ya
don't have to see anyone.

blood is drawn.



poetry

'poetic truth'

1

to me →

more than this, more than what 'really happened'

A short story,
A way of expressing emotion
internalising emotion,
A song without music.

images, metaphores, illustrations.
'moment of belief'
conviction. Believe in it - come into my world.

capture moment like camera.

2

"We learn to write by imitating, and, importantly, by reading." (2)

They should mean one thing. not many.
A close up of an moment in tiny detail"