Consultation on Future Arrangements for Early Medical Abortion at Home

RESPONDENT INFORMATION FORM

Please Note this form **must** be completed and returned with your response.

To find out how we handle your personal data, please see our privacy policy: https://www.gov.scot/privacy/

Are you responding as an individual or an organisation?

☐ Individual

☒ Organisation

Full name or organisation's name

Christian Concern	

Phone number

Address

70 Wimpole Street London

Postcode	W1G 8AX
Email	Tim.dieppe@christianconcern.com

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☒ Publish response with name

☐ Publish response only (without name)

Information for organisations:

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

☐ Do not publish response

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

☒ Yes

☐ No

If you wish to respond to this consultation by email or by post please provide your responses and any comments on the next page.

Consultation Questions

Where options are given please check or add a cross in the box next to the option which most reflects your views.

Question 1. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had on **women accessing abortion services**? Please answer with regards to the following criteria:

a) **safety**

☐ No impact

☐ Positive impact

☒ Negative impact

☐ The impacts are mixed

b) **accessibility and convenience of services**

☐ No impact

☐ Positive impact

☐ Negative impact

☒ The impacts are mixed

☐ I don't know

c) **waiting times**

☐ No impact

☐ Positive impact

☐ Negative impact

☒ The impacts are mixed

☐ I don't know

Comments (optional):

1a safety:

The removal of the requirement for a face-to-face consultation means that:

1. Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed with a Mystery Client Investigation sponsored by Christian Concern which found that in all cases women were able to obtain the pills by providing false information. There is also evidence from a leaked email and from press reports that women have taken these pills well beyond the gestational limit of 10 weeks, with significant safety risks as a result.

2. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. A leaked email revealed that the Care Quality Commission were aware of 13 serious incidents relating to home abortions as of 21 May 2020. These included ruptured ectopics, major resuscitation for major haemorrhage, and delivery of infants up to 30 weeks gestation. Three police investigations were linked to these incidents.
3. Providers cannot confirm the identity of the woman requesting abortion pills. This has been demonstrated with the Mystery Client Investigation which Christian Concern sponsored which found that all clients were able to obtain pills using false identities. This means that the pills could be obtained for another person and that another woman could be pressured or forced or deceived into taking them with significant safety concerns.
4. Providers are unable to check that the woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure.

1b accessibility and convenience of services:

Telemedicine may be cheaper and quicker than an in-person appointment, but the aim of medical care is not merely to adopt the cheapest or quickest approach. The Mystery Client Investigation which Christian Concern sponsored demonstrates that a telemedicine system is wide open to abuse and deception. Accessibility and convenience come at the severe price of not providing proper care and attention. Where complications arise, the accessibility or convenience may well be a subject of regret. The same applies to abuses of the system and the fact that such a system increases the accessibility and convenience of abortion pills to abusers.

Where cost is a barrier to attending the clinic in person, we recommend that financial assistance should be provided by the NHS to enable an in-person consultation.

1c waiting times:

Speed of service is not the primary aim of healthcare. Evidence from the Mystery Client Investigation which Christian Concern sponsored shows that telemedicine calls were frequently rushed with extraordinarily little meaningful engagement with the individual women about their circumstances or reasons for seeking an abortion. The whole process is highly rushed too, meaning that decisions are more likely to be made under pressure or in a rush of emotion. Having an abortion is a very significant and important decision which should not be made in a rushed manner without proper consultation. Removing the need for an in-person assessment increases the risks of rushed decisions which are later regretted.

Question 2. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had for **those involved in delivering abortion services**? (For example, this could include impacts on workforce flexibility and service efficiency.)

☐ No impact

☐ Positive impact

☒ Negative impact

☐ The impacts are mixed

☐ I don't know

Comments (optional):

The majority of healthcare professionals will not be satisfied with a telemedicine assessment of the patient when they know that this is not sufficient to properly assess the safety and suitability of the treatment. Caring professionals thrive on personal contact with their patients, including informal interactions which are not possible with telemedicine.

Question 3. What risks do you consider are associated with the current arrangements for early medical abortion at home (put in place due to COVID-19)? How could these risks be mitigated?

Comments:

We refer you first to the answer given for question 1 above for an explanation of the safety risks which we repeat here.

The removal of the requirement for a face-to-face consultation means that:

1. Providers cannot confirm the eligibility of a woman for early medical abortion at home. This has been clearly confirmed with a Mystery Client Investigation sponsored by Christian Concern which found that in all cases women were able to obtain the pills by providing false information. There is also evidence from a leaked email and from press reports that women have taken these pills well beyond the gestational limit of 10 weeks, with significant safety risks as a result.
2. Providers cannot confirm that it would be safe for the woman to have early medical abortion. Providers are unable to carry out a scan with telemedicine. A scan could reveal issues with the pregnancy which mean that the pills would be unsafe to take. A leaked email revealed that the Care Quality Commission were aware of 13 serious incidents relating to home abortions as of 21 May 2020. These included ruptured ectopics, major resuscitation for major haemorrhage, and delivery of infants up to 30 weeks gestation. Three police investigations were linked to these incidents.
3. Providers cannot confirm the identity of the woman requesting abortion pills. This has been demonstrated with the Mystery Client Investigation which Christian Concern sponsored which found that all clients were able to obtain

pills using false identities. This means that the pills could be obtained for another person and that another woman could be pressured or forced or deceived into taking them with significant safety concerns.

4. Providers are unable to check that the woman is not being coerced. There is not a safe private space for the woman to talk freely about whether she really wants to have the abortion or is doing so under pressure.

All of these risks would be mitigated or removed by reinstating the requirement for an in-person clinical assessment for early medical abortion.

Question 4. Do you have any views on the potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) **on equalities groups (the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation)?**

☒ Yes

☐ No

☐ I don't know

If yes, please outline possible impacts below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

1. The protected characteristic of pregnancy.
   Pregnant women are in a high-risk category for domestic abuse, including pressure from their partners to obtain an abortion. The provision of DIY abortion increases the risk of pregnant women being pressured into having an abortion or even being deceived or pressured into taking abortion pills which have been obtained deceptively. The covid pandemic has seen increased levels of domestic abuse and the provision of telemedicine abortions has only increased the risks and pressures in this area.
2. The protected characteristic of religion.
   Increased use of telemedicine abortions by post could result in more hospital and clinic staff being asked to indirectly be involved in the provision of abortion services, such as by posting pills to patients. Many of these staff will have a conscientious objection to abortion due to their religious beliefs and this should be taken into account in enabling such staff to opt out of providing any related services.

Question 5. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) **on socio-economic equality?**

☒ Yes

☐ No

☐ I don't know

If yes, please outline possible impacts below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

Comments:

Poverty or the perceived threat of poverty can drive women towards abortion. Government data shows that abortion rates in Scotland are twice as high in the most deprived areas than the least deprived areas. This means that women in the poorest areas will have less children and are more likely to suffer from the various risks and complications from early medical abortion at home outlined in our answer to question 1.

To mitigate this, financial assistance could be provided to enable women to travel to have an in-person clinical assessment prior to early medical abortion.

Question 6. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on **women living in rural or island communities?**

☒ Yes

☐ No

☐ I don't know

If yes, please outline possible impacts below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

Comments:

UN and WHO guidelines suggest that early medical abortion can be safely self-administered by the woman, as long as she is able to easily present at an appropriate healthcare facility if needed. BPAS indicates on its website that at least 3% of women with gestational age of less than 9 weeks will require surgical treatment to complete the abortion. This rises to 7% in the ninth week and will be higher for some women in Scotland where the regulatory limit for EMA is 11w6d.

Volunteers in the Mystery Client Investigation which Christian Concern sponsored were routinely advised by the abortion providers to monitor their bleeding and other side-effects, and if bleeding became worrying to go immediately to their nearest A&E or emergency department.

To mitigate these significant risks, women living in rural or island communities should be required to attend a regulated abortion clinic where proper medical care can be provided.

If necessary, financial assistance should be provided to enable the women to travel to an abortion clinic.

Question 7. How should early medical abortion be provided in future, when COVID-19 is no longer a significant risk? [select one of the options below]

☐ a) Current arrangements (put in place due to COVID-19) should continue – in other words allowing women to proceed without an in person appointment and take mifepristone at home, where this is clinically appropriate.

☐ b) Previous arrangements should be reinstated – in other words women would be required to take mifepristone in a clinic, but could still take misoprostol at home where this is clinically appropriate.

☒ c) Other (please provide details)

Comments:

As a minimum, the previous arrangements should be reinstated so that the various risks and safety concerns outlined above are mitigated or removed.

In addition, we recommend that financial support is provided where required for women to be able to travel to abortion clinics.

We propose further, that both pills should be taken in a clinic so that women are properly cared for if complications arise. Following taking misoprostol, the woman should remain in the care of the clinic until the abortion is completed, with resuscitation equipment and trained emergency medical staff available throughout.