Christian Medical Fellowship

Medical abortions briefing

There are two main types of abortion: medical (taking an abortion pill) and surgical. Medical abortions are most commonly used for early terminations, up to nine weeks, but can also be used for later abortions.[1] Medical abortions accounted for 65% of abortions in England and Wales in 2017,[2] and for 84% of the total in Scotland.[3]

In a medical abortion an oral dose of *mifepristone* is given at a clinic/hospital which will (usually) kill the fetus. Women leave the hospital or clinic and then return up to 48 hours later to be administered *misoprostol*, either orally or vaginally. This expels the dead fetus. In October 2017, Scotland allowed women to take *misoprostol* outside of a clinical setting.[4] Wales and England will follow suit by the end of 2018.[5]

1.Medical abortions lead to more complications than surgical

More bleeding
The RCOG reports that women are more likely to seek medical help for bleeding and haemorrhaging after medical abortion than after surgical abortion.[6] In trials, 90% of women reported bleeding more heavily than during a heavy menstrual period.[7]

The largest and most accurate study of medical abortions, the Finnish record-linkage study of 42,600 women, found that women had four times as many serious complications after medical abortions than surgical abortions: 20% compared to 5.6%. Rates of haemorrhage were 15.6% after medical compared to 2.1% after surgical abortions.[8] Another Finnish study of 24,000 women who had a medical abortion found that 15.4% were later diagnosed with bleeding, 2% had an infection, 10.2% an incomplete abortion, and 13% had to proceed with a vacuum curettage.[9]

A recent study in Sweden collected data from nearly 5,000 abortions. Between 2008 and 2015 the rate of complications for medical abortions under 12 weeks' gestation doubled – increasing from 4.2% to 8.2%. Complications from surgical abortions were 5.2%. Moreover, of medical abortions: '*The complication frequency was significantly higher among women < 7 gestational weeks who had their abortions at home*.' (7.3% compared to 2.4% at hospital). The authors also note that the rate of complications is probably an underestimate.[10]

Several other studies published in the last ten years show similar differences, with the rate of necessary surgery after an early medical abortion ranging from 3.5% to 7.9% and up to 33% for later abortions.[11] Therefore, around one out of every 20 women obtaining an early medical abortion will need surgery for haemorrhaging or to remove fetal remains left inside the uterus.

More complications
Hospitalisation rates are worse for medical abortions, particularly for later abortions.

For early medical abortion, a major review in 2011 of nearly 7,000 abortions performed in Australia reported hospitalisation rates of 5.7% following early medical abortion compared with 0.4% for patients undergoing first trimester surgical abortion. The authors concluded: '*The findings that women were more likely to be admitted and to have D&C surgery after early medical abortion than they were after early surgical abortion are consistent with the results reported in one much larger and one more tightly controlled series.*'[12]

For second trimester medical abortions, surgical intervention rates vary between studies ranging from 2.5% in one study and up to **53% in a UK multicentre study**.[13]

An Australian review of 7,000 abortions found that for later medical abortions: '*Following mid trimester medical abortion, emergency department presentation and subsequent admission were frequent.* ***Manual removal of placenta and the high rate of unplanned surgical intervention (rate of 32%) in these cases imposes additional costs as well as placing demand on operating theatre resources.***'[14]

These additional costs (and associated risks) of unplanned, often out of hours, surgical intervention are primarily borne by hospitals and not abortion clinics.

Since the deaths of at least 22 women in the USA from taking mifepristone, plus several cases of severe infection and at least 1445 cases with adverse effects since 2012 (289 per year),[15] the FDA has updated its guidance on mifepristone.[16] The medication guide warns that it can cause several serious side effects.[17] Mifepristone is only available in the USA through a restricted medical program (REMS) and only in certain healthcare settings.[18]

More painful
Taking these strong drugs is not to be undertaken lightly; a mifepristone medication guide from 2016 warns that *nearly all women* using *mifepristone* report adverse reactions. Women typically experience abdominal pain, including uterine cramping; and commonly report nausea, vomiting, and diarrhoea.[19]

Women's experiences are more painful later in gestation, with an exponentially increasing rate of haemorrhage and complications after seven weeks gestation.

Little reliable data to verify safety
Not all women who experience complications will return to the abortion provider or report the use of the drug to hospital services, so the numbers of adverse effects are likely to be higher. Some websites encourage women to say that they are having a miscarriage, not an abortion.[20]

Abortion clinics (mainly run by BPAS and Marie Stopes International) are not routinely required to record the woman's NHS number,[21] thus subsequent women's health events cannot easily be linked back to the abortion, and longitudinal research is almost impossible.[22] This lack of data means that the outcomes of abortion (any adverse effects) cannot be easily tracked in England and Wales. In other words, many complications are *missed off records* and not collected by Government stats.

2. Self-administered medical abortion is medically risky

Campaigner for abortion, obstetrician Peter Bolyan**,** has expressed concerns about women taking pills without regulation or medical supervision: '*there are serious dangers when women take them without supervision. We have knowledge of women who have taken them in excessive dosage and that can result in catastrophe for a woman such as a rupture of the uterus with very significant haemorrhage…****And if that happens in the privacy of a woman's home or perhaps in an apartment somewhere, that can have very, very serious consequences for women.*** *So, it's really important that these tablets are…dealt with in a supervised way…*'[23]

There is limited data on the outcomes of self-administering abortion pills, but one peer reviewed study found that 78% of participants had excessive bleeding, 13% had severe anaemia and 5% shock.

63% had an incomplete abortion and 23% had a failed abortion. They also found that surgical evacuation had to be performed in 68% of the patients, 13% with a blood transfusion. The authors concluded that: *'Unsupervised medical abortion can lead to increased maternal morbidity and mortality*.'[24]

The second visit to a medical clinic builds in an important safety feature by allowing for direct observation and monitoring of the administration of *misoprostol* at a precise time, method and place after *mifepristone* administration.

Self-administering removes control over timing
The later medical abortions take place, the less effective and the more dangerous they are. Ten weeks is the maximum gestation recommended.[25]

Importantly, *misoprostol* is recommended to be taken 24 to 48 hours after *mifepristone,* otherwise its effectiveness is significantly lowered.[26] One study (by authors who campaign for abortion) found that using *misoprostol* sooner than 24 hours after *mifepristone* leads to a significantly increased failure rate: women under seven weeks gestation had a failure rate of 27% while women between seven and eight weeks gestation had a failure rate of 31%. The authors of this study recommend that buccal misoprostol not be taken immediately after mifepristone because of the high abortion failure rate.[27] A further study also concludes that a six-hour gap '*…is not as effective at achieving a complete abortion compared with the 36- to 48-hour protocol*.'[28]

Research has shown that women have a strong preference for a short time interval between taking mifepristone and misoprostol, and consequently may well be inclined to take it more quickly.[29] Yet there would be nothing to stop a woman taking the pill outside of the recommended hours if she is outside medical supervision.

Self-administering removes control over following instructions
It cannot be assumed that all women will follow, understand or even be able to read the directions before taking the powerful drug. There is no legal requirement for a woman to follow medical instructions and there is no monitoring, so there can be little (if any) control over following instructions. A meta-analysis of 20 studies in 2015 warns of the: '*paucity of data on the actual time interval at which women actually administer misoprostol when instructed'.*[30]

Self-administering removes control over correct administration
Vaginal and buccal administration is generally recommended over oral, but if a woman gets frustrated and uncomfortable with keeping the misoprostol pill between her cheek and gum for the full 30 minutes (the tablets are unpleasant to taste and take this time to dissolve) and instead chews it up and swallows it early, she has just converted a 'buccal' administration into an 'oral' administration.

However, taking misoprostol orally, combined with the lower dose of mifepristone, is not as effective and results in a higher failure rate.[31] Correct administration is therefore essential for effectiveness.

Self-administering removes control over where pills are used
There is no control over:

- who takes the pills
- where the pills are taken
- whether the pills are taken (or sold on, or given to someone else)
- when in the process the pills are taken

- if the woman is vulnerable or in an abusive/coercive relationship[32]
- If abuse or coercion is involved in taking the pills.

Self-administering gives no guarantee that an adult is present in the home
The Scottish guidance underlines the absolute necessity of a woman having another adult at home when she takes *misoprostol*.[33] However, there is no provision or requirement for any confirmation of this even if a woman lives alone at home. There is no requirement to ensure that the adult is mature and capable of supervising a medical abortion. Is a 16-year-old appropriate? Or an abusive partner or pimp?

The Welsh Government has not even specified that an adult be present.

Moreover, home may be miles from a hospital. In view of the high rates of bleeding and haemorrhaging after medical abortion, there are clear dangers if a woman is unable to reach a hospital quickly in an emergency, or if the home has no working telephone (or other basic equipment) in a crisis.

3.There is no demand for self-administration of medical abortion

It is argued that women want to take the pill at home because they often experience bleeding on the way home.[34] Yet RCOG President, Professor Lesley Regan, has admitted[35] that there is no hard evidence or data showing that women are having problems with the current arrangements. Campaigners rely instead on (limited) anecdotal evidence.

Onset of bleeding is within four to six hours after taking *misoprostol*, giving sufficient time for most women to get home.[36] Surgical abortion is an option for those who cannot get home before bleeding begins, including those who cannot access medical services quickly after the abortion.

Medical abortion is contraindicated for women with transport problems *or* living a distance from the clinic. Women should not be offered medical abortion if they are not easily available for follow-up contact, medical evaluation or accessible to emergency services. Surgical abortion is an option for women with genuine transportation difficulties.

Moreover, medical abortion is not the same as miscarriage treatment. In a miscarriage the fetus is already dead. Therefore medical treatment for miscarriage only requires a dose of *misoprostol* not *mifepristone*,[37] as opposed to abortion which requires both. So, timing and manner of administration are much less significant.

4.The abortion industry is behind the campaign

Abortion providers (with obvious financial and ideological vested interests in increasing numbers of abortions) are driving the campaign to remove the administration of *misoprostol* from medical supervision and oversight.[38]

Stella Creasy MP makes this clear: '*I am proud to have been able to work on this issue with the Alliance for Choice, the London Irish Abortion Rights Campaign, the **British Pregnancy Advisory Service**, the Family Planning Association, **Marie Stopes** and Amnesty International.'*[39] These organisations are all behind the campaign to increase numbers of abortions.[40]

The longer-term goal for abortion lobbyists is to make obtaining a medical abortion as easy as possible, using nurses and pharmacists or internet suppliers, and to remove legal restrictions on abortion.[41]

There is also pressure to expand use of medical abortions at home to the first trimester (not just the first nine weeks) and beyond,[42] despite the exponentially increasing rate of haemorrhage and complications after seven weeks gestation. For women over seven weeks the failure rate is up to 33%.[43] There is also pressure for *mifepristone* and *misoprostol* to be given simultaneously, not 24 hours apart.[44]

Note that well-known abortion pill suppliers also encourage women to obtain pills via the Internet,[45] they encourage women to lie about taking the pills and they advocate bypassing legal restrictions.[46]

5. Recommendations

Instead of changing the current process, we recommend:

- Research to track women accurately during and after medical abortion, to review rates of complications during and after medical abortion and to assess the costs of surgical interventions after medical abortion at both NHS hospitals and private abortion clinics.

- Routine recording of women's NHS numbers at private abortion clinics for accurate longitudinal research.

- Ensuring that informed consent includes mention of all options and risks to women, *even very small risks* (otherwise doctors are at risk of breaking the law).[47]

- Informing women that the effects of mifepristone may be reversed if they want to stop the medical abortion process, with no apparent increased risk of birth defects.[48]

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