Scottish Government: Consultation on Future Arrangements for Early Medical Abortion at Home

The questions below are copied from the online consultation response form. Our responses are in black.

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 **X**

The impacts are mixed

I don't know

Comments (optional):

The absence of face to face consultation:

1) removes the physical examination that would confirm gestation dates. There is evidence that pregnancies that are well past 11 weeks and 6 days are being terminated at home, with increased safety risks a consequence*

2) removes scanning that would reveal if a pregnancy is ectopic

3) removes a safe place for a woman under coercion to speak freely

4) allows impersonation - is the woman requesting abortion the same woman that will take the medicines?

5) removes an opportunity for reflection - time to consider options in a non-pressurising context.

* A leaked e-mail from a Regional Chief Midwife (NHS England and NHS Improvement), on 21 May 2020, reported that the CQC were aware of 13 'incidents' relating to the process, including ruptured ectopic pregnancies, major haemorrhage, and the delivery of infants up to 30 weeks gestation. Two maternal deaths were included. The e-mail refers to three police investigations, including one investigation of murder where a baby had been live born. All these incidents had occurred within the first two months of the Covid-19 provisions for abortion being introduced. There is no suggestion in the e-mail that this number represents the total number of such incidents, simply those that had come to the knowledge of the CQC at that time. As no effective mechanism for the reporting and audit of complications arising from the process is in place, it seems inevitable that the numbers reported above, from one region, and in a period of only two months, represent but the tip of an iceberg.

A nationwide undercover investigation, commissioned by Christian Concern showed that 'home abortion schemes are wide open to abuse' and are 'leading to dangerous and illegal 'DIY' abortions.' Kevin Duffy, ironically a former Global Director of Clinics Development at Marie Stopes International, who led the investigation, said: 'The investigation clearly demonstrates that abortion at home, by pills-by-post, is not safe and on many occasions oversteps legal boundaries without any proper scrutiny....It is deeply concerning that the abortion industry has been allowed to take this service this far during an already highly vulnerable time for pregnant women. The process of wholly relying on telemedicine must be withdrawn urgently.'

b) accessibility and convenience of services

No impact

Positive impact

Negative impact

The impacts are mixed **X**

I don't know

Comments:

Increased accessibility may be of benefit to those living in remote areas, but the greater speed and ease of access generally is not necessarily helpful. By 'streamlining' the process, the essential need for a period of calm reflection and access to non-directive counselling, is denied. It is inevitable that this will lead to more women regretting decisions made in a hurry and without information and support.

There is evidence that abortion agencies BPAS and Marie Stopes fail to offer non-directive counselling or time for reflection. Why would they, when it is in their commercial interests to maximise the number of 'low-cost' abortions? To entrust the safety of the process into the hands of these providers is irresponsible to the point of neglect.

c) waiting times

No impact

Positive impact

Negative impact **X**

The impacts are mixed

I don't know

Comments:

Decisions made hurriedly, in a time of anxiety or under pressure from others, are more likely to be regretted subsequently.

We appeal strongly for the mandatory provision of independent and non-directive information and support for all women considering an abortion, and a 'cooling-off' period of at least 48 hours for reflection, to be built into the process.

This must not be left to the abortion providers to supply; it is self-evident that those who profit from abortion cannot provide truly independent information and support.

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 **X**

The impacts are mixed

I don't know

Comments (optional):

The overwhelming majority of healthcare professionals are highly motivated to deliver the best care possible for their patients. An induced abortion, even at an early stage, is a traumatic experience, emotionally as well as physically, even when it is without complication. Caring professionals will want to be alongside their patients at such times, and COVID-19 restrictions have prevented them from doing the best by their patients. This has caused both professional frustration and injury to their personal moral intuitions. To perpetuate this one week longer than COVID-19 security necessitates would be harmful. Offering appropriate care and support will always trump 'service efficiency.'

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:

See answer to Q.1

In our opinion, face to face consultation is essential, to ensure accuracy of dates, to guard against coercion, to decide if a scan is indicated (either to confirm dates or to rule out an ectopic pregnancy), to provide unbiased information and non-directive counsel, to afford an opportunity to the mother to reflect and consider other options.

The decision to terminate a pregnancy is a profoundly significant one. From the earliest days of her pregnancy, a woman's intuition is to provide a welcome and a safe place in her womb for her baby. The choice to abort is costly and may lead to later regret. We believe that the initial consultation should be with her doctor and that that doctor should routinely have to account for his or her decision to another doctor, who may affirm or resist his or her colleague's decision.

We believe that this level of care and involvement is essential to the patient's best interests and sufficiently important to justify the small risk of COVID transmission when undertaken in a COVID secure environment with appropriate PPE etc.

As part of this consultation, we (the Scottish Government) also wish to consider the likely or possible impacts (both positive and negative) on different groups of women, of allowing the current arrangements to continue permanently. This includes women who share a protected characteristic as defined by the Equality Act 2010[11], including disabled women, younger women, minority ethnic women and women who share a particular religion or belief, as well as women who have childcare or other caring responsibilities. We also wish to consider the likely or possible impacts (both positive and negative) on trans men who require access to abortion services, of allowing the current arrangement to continue.

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 **X**

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.

In addition to the groups discussed above, we also want to seek views on the potential for making permanent home use of both pills for early medical abortion to reduce or increase inequality in health outcomes experienced by different socio-economic groups. This is in particular to help ensure we meet our responsibilities under the Fairer Scotland Duty to help tackle inequalities caused by socio-economic disadvantage.

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 **X**

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.

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 **X**

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.

We appreciate that not having to wait for a GP to visit a remote island community, or not having to take a day trip to visit a mainland doctor for a consultation, could be viewed as a significant advantage. However, we would argue that better to be inconvenienced early on than be put at risk later in the process when emergency help might not be at hand. On balance we believe that women living in rural and island communities would be better served, and safer, under a provision that mandated face-to-face consultations.

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) **X**

Initial clinical assessment by a healthcare professional, provision of non-directive information, routine pre-decision counselling and time for reflection, face to face consultation with a doctor and follow-up support including a check pregnancy test, should all be routine. None of these functions should be left to abortion-providers to supply.

Both pills should be taken in a clinic. Following misoprostol, the woman should remain in the care of the clinic until the abortion is deemed to be complete. Resuscitation equipment and staff trained in its use must be on hand at all times.