RightToLife

# Consultation guide

Scottish Government's consultation on Future Arrangements for Early Medical Abortion at Home

**Right To Life UK**

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# Introduction

**The Scottish Government has launched a consultation on whether to make the current temporary arrangement allowing 'DIY' home abortions to take place in Scotland permanent.**

The consultation closes at 11:59 pm on January 5, 2021.

Full details on the consultation are available here: https://www.gov.scot/publications/consultation-future-arrangements-early-medical-abortion-home/

# How to respond

### Online - via consultation hub

1. Visit https://consult.gov.scot/population-health/early-medical-abortion-at-home
2. Complete the process
3. Submit

Please note - You can save and return to your responses while the consultation is still open.

### Post or email

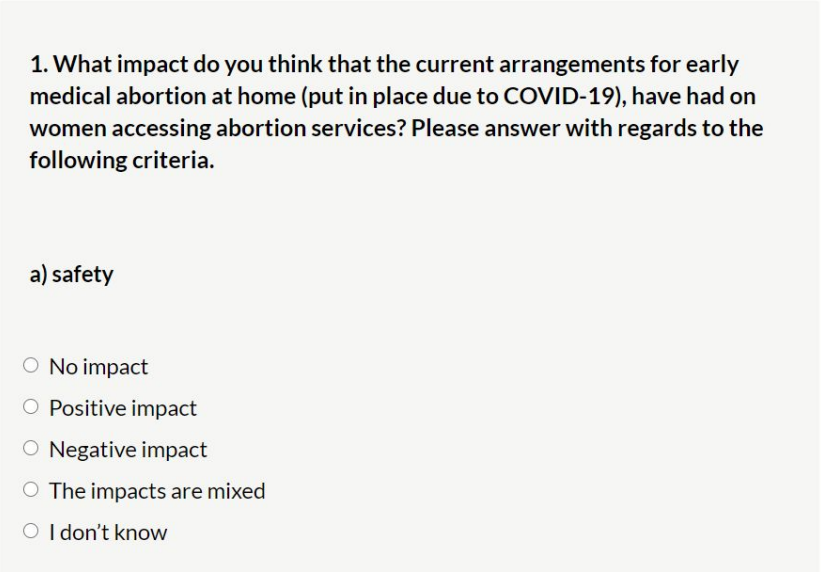
1. Download the Respondent Information Form from here:
    a. https://www.gov.scot/binaries/content/documents/govscot/publications/consultation-paper/2020/09/consultation-future-arrangements-early-medical-abortion-home/documents/respondent-information-form/respondent-information-form/govscot%3Adocument/respondent-information-form.docx
2. Add your responses to the form
3. Return your completed form to:
    a. Email: abortionconsultation@gov.scot
    b. Post: Abortion Consultation
    Health Protection Division
    Scottish Government
    Area 3E, St Andrew's House
    Regent Road
    Edinburgh EH1 3DG

# Consultation response guide

**For each question, we have provided a suggested answer and points that will be helpful to cover in the comments sections.**

It is important that you put the comments into your own words in your submission. Please also add anything that is helpful from either your personal or professional experience with the issues covered.

## Question 1 a



**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
- ○ I don't know

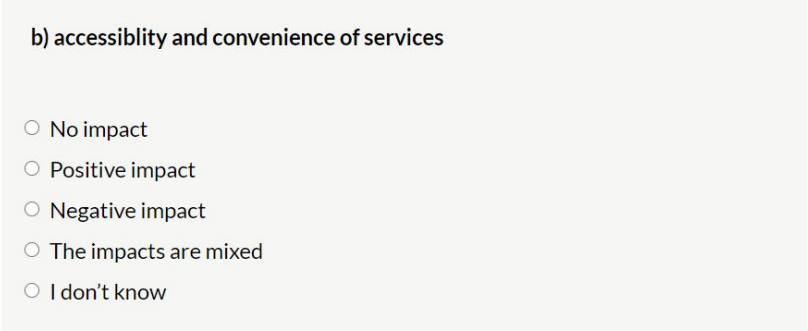
**We suggest that you select "negative impact".**

**Points that can be included in the optional comments section.**

- Incidents of significant complications relating to the self-administration of medical abortion pills demonstrate that the consequences of at-home abortion are extremely serious. See for example reports of babies being aborted at 28 weeks, the testimonies of women who have had medical abortions at home, and a leaked email sent by a Regional Chief Midwife at NHS England and NHS Improvement on the 'escalating risks' of the 'Pills by Post' service. Specifically the leaked email details that:
    - There are 3 police investigations linked to late 'DIY' home abortions, including a 'murder investigation as there is concern that the baby was live born'
    - A woman at 32 weeks of pregnancy was able to receive 'DIY' home abortion pills (this was 'a near miss,' as the 'woman had received the pills

by post and then wished for a scan and so attended a trust, and was found to be 32 weeks')
    - There have been incidents involving the 'delivery of infants who are up to 30 weeks gestation'
    - Women had to attend the Emergency Department for a range of incidents including 'significant pain and bleeding related to the process through to ruptured ectopics', and 'major resuscitation for major haemorrhage.'
    - A further 13 incidents were under investigation (specifically, the email notes that the body who would investigate these matters, the CQC, 'are aware of 13 incidents related to this process').
- There is no guarantee that women will follow the recommended protocols for taking abortion pills, or follow them correctly. A review of patient adherence to treatment, for example, found that "poor compliance is to be expected in 30–50% of all patients, irrespective of disease, prognosis, or setting".
- There is a lack of high-quality research study designs and risks of bias in existing data on unsupervised home abortion, as noted in the Cochrane Systematic Review 2020, which concludes "[I]t remains unclear whether self-administration of medical abortion is effective and safe."
- There is a high risk of potential coercion and abuse, as demonstrated by a recent investigation.
    - The same investigation shows women can easily obtain abortion pills even when beyond the legal time limit for 'at-home' abortion, as there is no in-person identification check and it is impossible to accurately diagnose gestation over the phone (that is, without an ultrasound or in-person examination).

## Question 1 b




**We suggest that you select "negative impact".**

**Points that can be included in the optional comments section.**

- As detailed in the recent report entitled 'Delivering core NHS and care services during the pandemic and beyond', not all individuals are able to access telemedicine.
    - Rethink Mental Illness stated that individuals are finding digital services 'impossible to engage with' and were left 'feeling abandoned'.
    - Blood Cancer Alliance noted that individuals for whom English is not a first language found it harder to follow online guidance and videos.
- Telemedicine also has a disproportionately negative impact on accessibility for people with mental health problems and disabilities; for example, mental health charity Mind have suggested that individuals may not feel comfortable talking about their mental health online, or may not be in an environment where they are safe to talk about their mental health.
- In-person checks are crucial to provide the highest standard of care for women, not least those suffering from mental health issues or domestic abuse.
- Polling suggests that women want more, not fewer, safeguards around abortion. In one poll, 77% of women agreed that doctors should be required by law to verify in person that a patient seeking abortion is not being coerced. Another poll shows that 92% of women agreed that a woman should always be seen in person by a qualified doctor.

## Question 1 c

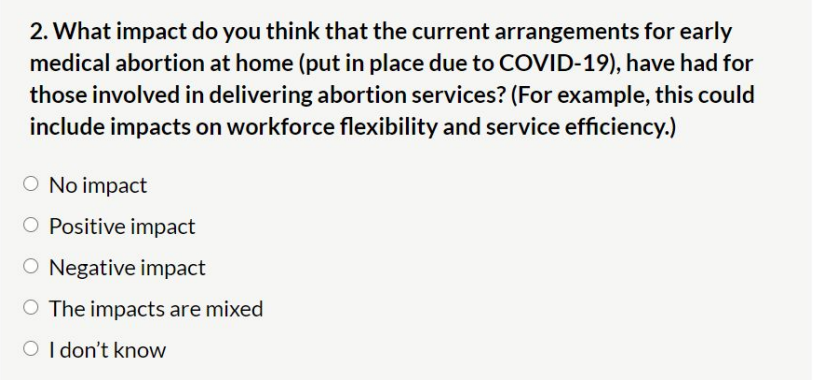

**We suggest that you select "negative impact".**

**Points that can be included in the optional comments section.**

- The Consultation Paper's claim that the 'reduced waiting times' provided by the temporary arrangements for 'at-home' abortion are likely to have led to women having earlier medical abortions is misguided. The data are not fully reliable (it is impossible to accurately verify gestational age over the phone, without

ultrasound or in-person examination), and even if the reliability of the data were accepted, the data does fully not support the claim.
    - The introduction of at-home abortion has not significantly shifted the prevailing trends in abortion practice but reflects an existing long-term trend towards a higher percentage of abortions occurring at under 10 weeks gestation, with a similar yearly percentage increase over several years.
- Expediency is the wrong measurement for a life-changing decision such as abortion where the effects can last a lifetime, though it seems to be presumed reduced waiting times would be a positive change. I disagree and would advocate for a consideration period, as many women struggle with the decision of whether to abort.
    - Also of note, 93% of women agree that a woman considering abortion should have a legal right to independent counselling from a source that has no financial interest in her decision.

## Question 2




**We suggest that you select "negative impact".**

**Points that can be included in the optional comments section.**

- Removing the in-person consultation requirement depletes the relationship between patient and physician. Notably, a lack of ability to effectively communicate through body language may hinder the outcome of a consultation, particularly where there may be a language barrier, meaning the physician may be less able to verify that the patient has given informed consent.
- It is not evident how abortion providers will be equipped to ensure that a woman is providing informed consent for an abortion of her own free will, potentially placing those delivering abortion services in a compromising position.

- It is not clear whether medical professionals may be held accountable for the patient's disposal of the fetus, particularly given that it is not guaranteed how the remains will be disposed of, and they could end up in an inappropriate setting.

## Question 3

**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?**

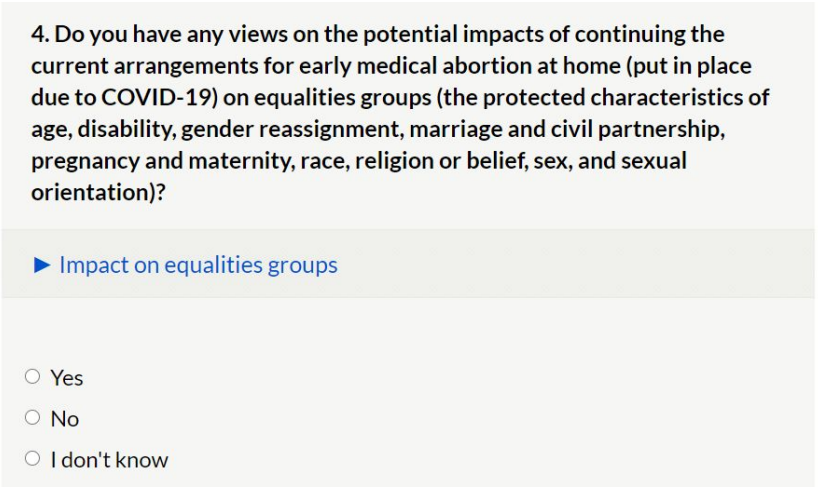
**Points that can be included in the optional comments section.**

- The lack of in-person consultation removes an opportunity to identify domestic abuse and abortion coercion. This may have a negative effect particularly on women in Scotland from minority ethnic cultures where women may be pressured into seeking a sex-selective abortion.
- Self-administration of abortion pills removes any control over who takes the pills, where they are taken, whether they are taken, when in the process they are taken, or if an adult is present.
- Home abortion puts women's physical health at risk. Concerns over the physical complications that can arise from unsupervised medical abortions have been raised by doctors - among others - including Dr Anthony Latham, chairman of the Scottish Council on Human Bioethics; Dr Gregory Gardner, in a legal witness statement; the Irish Minister for Health Simon Harris and the chair of the Institute of Obstetricians Peter Boylan; an NHS Regional Chief Midwife, and the Northern Ireland Department of Health.
    - Notably various studies:
        - Link increases in complications from medical abortions to the shift from in-clinic to home medical abortions
        - Conclude that surgical evacuation rates due to incomplete abortion are higher for medical abortion through telemedicine than for in-person medical abortion care
        - Have found that there can be more complications following taking abortion pills than following surgical abortions.
    - Physical complications include ruptured ectopic pregnancies (it is impossible to confirm ectopic pregnancies via a phone call/without an ultrasound, particularly as some ectopic pregnancies are asymptomatic), haemorrhaging, isoimmunisation in future pregnancies, where the mother produces antibodies that harm the baby's blood cells, and in pregnancies that continue to birth following the taking of misoprostol,

teratogenic effects such as clubfoot, limb and cranial nerve abnormalities have been reported.

- Home abortion puts women's mental health at risk.
    - Abortion is a life-changing decision that affects each woman differently. Women may be unsure of their decision and may require more in-depth, unrushed face-to-face counselling before their termination rather than a phone call. The current early medical home abortion scheme does not make provision for this.
    - Research suggests that mifepristone may have direct pharmacologic effects that increase risk of mental health issues and complications such as infection.
    - Women who have experienced home abortion have expressed the negative impact it has had on their mental health, for example 31 year old Nikita Jones described the experience and aftermath as "traumatic", whilst another woman commented "I didn't look [at the fetus] because I knew it would upset me".
- The Northern Ireland Department of Health has recently warned that 'women 'are at risk' if they choose to pursue do-it-yourself terminations.' Specifically, the Department believes 'that services should be properly delivered through direct medical supervision within the health and social care system.' *(Currently Northern Ireland does not permit the taking of both abortion pills at home.*)
- The best way to mitigate these risks, indeed the only way to ensure they are properly addressed, is by immediately withdrawing the temporary provision allowing 'DIY' home abortion and requiring an in-person consultation prior to women receiving a medical abortion.

## Question 4




**We suggest that you select "yes".**

**Points that can be included in the optional comments section.**

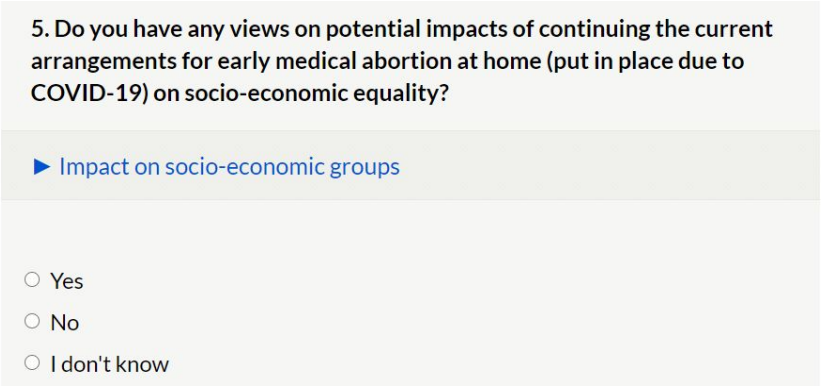
- Prolonging the provision of medical abortion pills at home will negatively impact pregnant women as an equality group, as it presents great risk to women's physical and mental health.
- Removing face-to-face consultations will negatively impact the consultation experience and decision-making process of women who would otherwise rely on in-person communication due to impaired hearing or vision, as well as those suffering debilitating mental health conditions and those exposed to coercion.
- Women suffering from poor mental health may be particularly badly served by the limitations of phone communication, and their individual difficulties may not be fully communicated over the phone to the listening medical professional.
- Significantly, whilst there is no mention of unborn children as a 'protected category', age is mentioned. In this section I believe it important to raise the impact that continuing 'DIY' home abortions will have on the rights of the very young - unborn children. That the unborn are not recognised as a protected age category or equality group in the text of this consultation - is extremely concerning.
- In Scotland, last year 13,583 abortions were recorded - the second-highest number of abortions in Scotland since the Regulations were introduced - whilst recent figures released from the Department of Health and Social Care show that abortions are continuing to rise and are at an all-time high in England and Wales. This is a grave healthcare failing for the UK that denies the right to life of unborn children as a protected equality group.
- It is possible for a woman may learn the sex of her unborn child as early as 7 weeks through non-invasive prenatal testing, and to learn whether her child has

Down's syndrome as early as 10 weeks. Tragically it is possible that a woman, after receiving the results of either test, may choose to abort for these reasons. Already, over 90% of babies prenatally diagnosed with Down's syndrome are aborted, while the number of babies born with Down's syndrome has declined by 30% in NHS hospitals that have introduced NIPT. Under the provision to allow 'at-home' abortion we could see an increase in both disability and sex-selective abortion.

    - The Nuffield Bioethics Council has highlighted "serious issues" with how some clinics and NIPT providers are marketing and offering the tests. Evidence from overseas shows that inaccurate communication and overselling of the precision of NIPT was resulting in parents incorrectly believing that their baby had a disability and proceeding with an abortion based on the results of the tests. An in-person consultation provides an opportunity for a trained medical professional to explain in-person that these tests only provide a probability that their child has a disability and to ensure that a woman does not proceed with an abortion based on the results of these screening tests. Without this safeguard in place, under the provision to allow 'at-home' abortion we could see an increase in both disability and sex-selective abortion.
    - Whether aborting based on sex or disability, it sends a cultural message to those living with disabilities and indeed to all women, that somehow their lives are less valuable or worthy.

- A continuation of the temporary arrangements for 'DIY' home abortion may negatively impact medical professionals with religious beliefs that would not allow them to participate in an abortion procedure. Notably, the Abortion Act (1967) ensures conscientious objection for any medical professionals engaged in direct participation - yet, as of now, it is unclear what would be considered direct participation. For example, would someone be able to opt-out of being required to post abortion pills to a woman's home? Clarity around this is urgently needed.

## Question 5




**We suggest that you select "yes".**

**Points that can be included in the optional comments section.**

- Equal access to a dangerous process is surely the wrong measurement of successful socio-economic equality.
- Removing face-to-face consultations may increase inequality in health outcomes experienced by socioeconomically disadvantaged groups including homeless women
    - First, with problems in accessing technology and a fixed postal address, and
    - Secondly as a missed opportunity to pick up on health issues that may not otherwise be addressed for women who are not undertaking routine GP check-ups.
- Women living in poverty or who are concerned about potentially falling into poverty through having a child may be more likely to seek abortion. That abortion rates are more than two times higher in the most economically deprived areas in Scotland than the least deprived, according to Government data, implies that women in poorer areas are currently more at risk from unsafe 'DIY' home abortions under the temporary ruling.
- In-person, face-to-face consultations should be mandatory for all women, especially those in vulnerable socioeconomic circumstances such as those on the poverty line and those lacking technological access and aptitude, who are disproportionately vulnerable to the dangers of 'DIY' home abortion.
    - Also, to omit an in-person clinical consultation is to potentially miss serious health issues that may threaten women's physical and mental health, such as an underestimated gestational date, symptoms of an ectopic pregnancy, and evidence of coercion or abuse.

## Question 6

**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

**We suggest that you select "yes".**

**Points that can be included in the optional comments section.**

- Pregnant women living in rural or island areas with limited access to healthcare are greatly disadvantaged by 'at-home' abortions, which can result in serious complications.
- The particular needs of those residing in rural Scotland should be taken seriously, especially the limited access to local hospitals.
    - Serious complications can and do arise from taking both misoprostol and mifepristone at home. In the absence of always convenient access to hospitals, 'at-home' abortions present a greater risk to residents of rural and island communities.
    - Prolonging the temporary out-of clinic medical abortion policy for women in these areas prolongs their exposed risk and entrenches the health access divide between urban and rural populations in Scotland.
- Women living in rural or island communities are much better served by the requirement of an in-person, face-to-face consultation, given its clear advantage in communication and care over 'DIY' home abortion.

## Question 7

**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) –

**We suggest that you select "b".**

**Points that can be included in the optional comments section.**

- At the very least, the previous arrangements should be reinstated. Preferably, however, both mifepristone and misoprostol should be taken in clinic, to ensure they are taken properly, at the appropriate time and in the appropriate manner.
- Under the current temporary arrangements, women are responsible for understanding and supervising their own symptoms of subsequent illness and various other complex aspects of medical self-administration. Moreover, the inability to remotely verify an accurate gestational date may result in a patient using misoprostol in a manner unrecommended or harmful for their health.
- Taking both pills in a clinic provides an added measure of safety for women so that, should they experience a complication, medical care is immediately accessible. As the guidelines for 'at-home' abortion themselves admit the benefit of accompaniment during the process, by the same logic, surely the attendance of an adult who can provide proper medical support would be even more beneficial.
- In the brief mention of the difficulties of judging gestational date or the presence of coercion, by virtual means, there is no evidence given to explain these concerns, yet these concerns are clearly reason enough to prohibit home abortion.
- Given the absence of critical information concerning the problems introduced by the implementation of 'at-home' abortion in England and Wales and the prior arrangements for abortion access, question 7 cannot be fairly answered by a respondent who has relied upon the consultation paper for '*validated impact assessments*' of the competing options. With the aid of outside research, it becomes clear that both forms of abortion pose serious risks to women (as well as resulting in the death of an unborn human being).
- At the very least, Scotland should revert to requiring the first pills be taken in-clinic, which would allow women to undergo a physical examination to ensure the safety and acceptability of such a procedure, through integral measures such as ultrasound scans.