Safeguarding and teleconsultation for abortion

Elizabeth Chloe Romanis, Jordan A Parsons, Isobel Salter, Thomas Hampton

In response to COVID-19 and measures implemented to control virus transmission, some governments adapted abortion law and policy to ensure access to abortion care through telemedicine.[1,2] In Great Britain, approval orders were issued March 30–31, 2020, making fully remote, no-test, early medical abortion temporarily lawful.[3] Professional guidelines were then issued to support providers in offering new remote services.[4] Other Organisation for Economic Co-operation and Development countries have also temporarily amended policies to enable remote consultation and at-home use of abortion medications: France,[1,2] Ireland,[1] and the USA[5] (panel). Others have enabled fewer face-to-face consultations, although abortion medications must still be collected or administered in-person—eg, in Estonia and Germany.[1] In most Organisation for Economic Co-operation and Development countries, however, laws continue to prohibit fully remote abortion provision.

There have been calls internationally to enable remote provision of abortion care where it is not yet available.[8] Where a change has occurred—eg, in Great Britain—this amendment has arguably resulted in clinically and ethically superior care,[9] spurring calls for telemedical abortion to become standard practice.[2,9] The International Federation of Gynecology and Obstetrics "recommends investment by governments around the world to strengthen the provision of and access to telemedicine."[10] Public consultations on making permanent changes to the law to allow for telemedical abortion in Great Britain closed between January and February, 2021.

Most objections to telemedical abortion by politicians and anti-abortion groups relate to women's safety, suggesting that administration of the medication at home is less safe and that teleconsultation limits health-care professionals' ability to perform adequate safeguarding assessments.[11] Increasing evidence shows that remote abortion care is at least as safe, effective, and acceptable to patients as face-to-face care,[12–15] so safety concerns about home administration of the drugs themselves are unfounded. In this Viewpoint, therefore, we focus on the safeguarding objection. In March, 2020, the UK House of Lords Under Secretary for Health and Social Care argued that "it is an essential safeguard that a woman attends a clinic, to ensure that she has an opportunity to be seen alone and to ensure that there are no issues…[without this] it is far more likely that a vulnerable woman could be pressured into…an abortion by an abusive partner".[16] In UK health care, safeguarding is the protection of vulnerable people's health, wellbeing, and human rights. England's Care Quality Commission[17] recognises safeguarding as an integral part of providing high-quality health care. In practice, safeguarding requires health-care professionals to consider the broader wellbeing of patients beyond the matter they are seeking care for, including, for example, addressing concerns about reducing harm outside of a health-care context.

We contend that concerns about safeguarding during teleconsultations are insufficiently evidenced to justify the reintroduction of the in-person requirement for abortion care in countries where this change has been made—including Great Britain. We argue that the burden of proof should rest on those campaign groups who consider safeguarding through remote care inferior, and that remote abortion care should remain lawful in the absence of compelling data to suggest otherwise.

Lancet 2021; 398: 555–58

Centre for Ethics and Law in the Life Sciences, Durham Law School, Palatine Centre, Durham University, Durham, UK (E C Romanis PhD); **Centre for Ethics in Medicine, Bristol Medical School, University of Bristol, Bristol, UK** (J A Parsons MScR); **Alder Hey NHS Foundation Trust, Liverpool, UK** (I Salter MBChB); **Institute of Life Course and Medical Sciences, University of Liverpool, Liverpool, UK** (T Hampton MBBS)

Panel: Organisation for Economic Co-operation and Development countries that made changes to laws or policies to enable fully remote abortion care in response to COVID-19

France
- National Health Agency Guidelines issued in April, 2020, stipulated that abortion by telemedicine would be temporarily permissible; gestational limit on home use of abortion medications raised to 9 weeks[6]

Great Britain
- Approval orders issued by health ministers in England, Wales, and Scotland in March, 2020, amended the law to enable fully remote abortion[2]
- Changes in England and Wales are explicitly temporary (until March, 2022, at the latest); changes in Scotland are not explicitly temporary, but the government initially announced an intention that the amendments would be revoked
- Remote abortion temporarily permissible until 9 weeks and 6 days' gestation in England and Wales, and a recommended limit of 11 weeks and 6 days' gestation in Scotland

Ireland
- Department of Health issued new guidance in April, 2020, enabling remote consultation and home use of abortion medications until 9 weeks' gestation[1]

New Zealand
- Abortion was decriminalised in New Zealand in March, 2020, meaning that there are now no criminal restrictions on abortions provided by health-care professionals before 20 weeks' gestation[7]
- This change to the law repealed the previously existing requirements mandating in-clinic administration of abortion medications; the changes meant it became technically possible for providers to begin offering abortion by telemedicine; the change in the law was not in response to the pandemic, but the action of some District Health Boards to quickly make changes in April, 2020, to enable telemedical abortion

USA
- The US Food and Drug Administration[5] announced in April, 2021, that they would cease enforcement of the mandatory in-person dispensing requirement for mifepristone during the pandemic
- This change temporarily ended the federal prohibition on fully remote abortion, but there remain considerable restrictions in many US states—some states have laws that explicitly ban abortion by telemedicine and others have mandatory in-person requirements in state law

Correspondence to:
Dr Elizabeth Chloe Romanis, Centre for Ethics and Law in the Life Sciences, Durham Law School, Palatine Centre, Durham University, Durham DH1 3LE, UK
elizabeth.c.romanis@durham.ac.uk

Before addressing the adequacy of remote safeguarding, the very fact that safeguarding is being centred in the discourse around telemedical abortion reiterates the problematic characterisation of women seeking to end unwanted pregnancies as being inherently vulnerable and in need of institutional support. It also implies that safeguarding affects many patients. Such inferences perpetuate harmful abortion stigma in attempting to justify why women need abortions,[18] rather than accepting that it is routine, essential health care. Abortion is routine health care in Great Britain (there were 207 384 abortions in England and Wales in 2019).[19] There is, therefore, also the matter of proportionality. Safeguarding processes certainly need to adapt to remote provision, but there is no evidence to suggest these adaptations cannot be satisfactorily achieved. Even if one disagrees that remote abortion care might only benefit the minority, it does not mean we should not offer this service when there are substantial benefits for the majority.[9,14]

The Abortion Act 1967[20] requires that two doctors be satisfied that a woman meets the so-called social ground for abortion before care is provided, but does not mandate that safeguarding be undertaken for vulnerable women before care is provided. However, health-care regulators require adequate safeguarding processes and health-care professionals have legal obligations to protect patients from harm.[21] Lawful medical treatment (including abortion) requires the capacitous patient's informed consent,[22] which must be given voluntarily.[23] Health-care professionals must, therefore, be attentive to whether they believe an individual is being pressured to undergo treatment. Royal College of Obstetricians and Gynaecologists guidelines suggest that health-care professionals providing abortion care should identify patients who might require additional safeguarding support, potentially including "young women, women with mental health problems, women with poor social support, or where there is evidence of coercion".[24] Voluntary consent might be thought to be more difficult to ascertain remotely, potentially because it cannot be confirmed that the patient is alone. There is not the same assurance as during an in-person consultation that a patient is not being supervised or their responses coached. In the absence of a face-to-face consultation, there is a worry that it is more difficult to pick up subtle non-verbal cues from the patient that indicate support needs.

These concerns about remote consultation are insufficiently contextualised. In many instances, a patient is no more likely to disclose coercion or welfare issues during an in-person consultation than they would be remotely. Many women in situations of intimate partner or family violence are prevented from attending a clinic in the first place. In a 2018 study, many women reported fear of repercussions from an abuser as the reason why they obtained abortion medications unlawfully online rather than attending a clinic.[25] The reality is that, without remote provision, many of the patients needing additional support do not have any contact with a health-care professional when having their abortion. Even when these women are attending clinics, there is no reason to suppose disclosure rates were any higher just because the patient was (definitively) seen alone. Coercive relationships affect a person's ability to disclose even if an abuser is not there.[26] Although an abuser can actively interfere by coaching a patient during a phone call, their control over the person being abused might remain during an in-person clinic visit when they are not there, for example, because the threat can still feel imminent to the person being abused. A patient is more likely to disclose if they are confident that their abuser is unaware, which might be easier if remote consultation is available—keeping a trip to the clinic a secret is difficult, whereas a remote consultation might be accessed when in the bathroom, in regularly attended safe spaces outside the home, or when the abuser is away from home.

Emerging evidence does not indicate that safeguarding cannot be done over the phone. The UK's two main abortion providers have reported an increase in enhanced safeguarding referrals since the introduction of remote care.[27,28] There are many reasons why some women might find attending a clinic or hospital intimidating—potentially because they anticipate an intrusive examination or being judged. Consequently, remote care could sometimes increase the likelihood of disclosure, and therefore telemedical services remaining after the pandemic might be beneficial for vulnerable women in terms of increasing the likelihood of them receiving adequate assistance when necessary. Patients can discuss their treatment with a health-care professional in a comfortable, familiar environment of their choosing, resulting in heightened engagement within the consultation. Some patients have reported finding the disclosure of intimate information or abuse easier in remote sexual health consultations.[29] If a patient is concerned about being seen attending a clinic, making an excuse to leave their home, or breaking with usual routines, they might be less anxious during a remote consultation. Their home might also be a space (or they might have space within it) away from their abuser. They might also have a safe space outside of the home to comfortably speak on the phone. This scenario will not be universally true, but some patients will be more likely to disclose when not in an intimidating clinical environment. Furthermore, insisting on an in-person appointment remains within clinical discretion of the consulting health-care professional if they are unsure as to whether the patient is speaking freely. In-person appointments are and should be available to satisfy concerns regarding consent and for patients who prefer in-person consultations.

Concerns about hindered communication during a remote consultation could be viewed more as an argument for updated training. Signs of concern can

still be recognised during a remote consultation through, for example, tone and strength of voice, or the extent to which a patient appears to be glancing over the screen. Over-reliance on body language can be remedied through appropriate training. The importance of remote consultation has already been recognised by the National Institute for Health and Care Excellence,[30] which recommended in 2019 that, for women who prefer it, abortion assessments can take place by phone or video call. Remote consultation is becoming more prevalent in most specialties given the National Health Service Long Term Plan,[31] compounding the importance of ensuring that health-care professionals are trained in, equipped for, and confident with remote communication.

Irrespective of whether a safeguarding assessment can be considered adequate when done remotely, there remains a medical need for the patient to access care. Accessing in-person abortion services can be challenging for women with poor social support, living in poverty, or who are victims of violence at home.[9,25] There is a sense of urgency in accessing abortion services because the treatment is safer the earlier it is undertaken and there are legally imposed gestational limits on treatment.[3,9] The urgency is often heightened for women experiencing intimate partner violence—not only to end an unwanted pregnancy, but also to prevent the increase in such violence often seen during pregnancy.[32] Without the option to access this care remotely, many vulnerable women seek it unlawfully by purchasing abortion medications online,[25,33] or are forced to continue an unwanted pregnancy. The absence of remote care is then forcing these women into a situation entirely devoid of safeguarding. Even if in-person care was considered to be the ideal, remote provision results in fewer women having no access to care or accessing care unlawfully. It has been found that fewer women in Great Britain have been using extra legal channels of access to abortion medication since the change in regulations, whereas use of unregulated, online abortion services has increased in countries where access to abortion care was not secured during the COVID-19 pandemic.[34] In enabling these women to access care through regulated health-care services, remote care affords them access to good-quality care alongside an appropriate standard of safeguarding support.[4,34] Continuance of telemedical abortion services after the pandemic is, therefore, necessary to ensure that vulnerable women have the same access to care.

Not only is there insufficient evidence to assume that safeguarding cannot be done adequately during remote consultations, but the underlying assumption that safeguarding concerns should prevent the permanence of this service is problematic. Although safeguarding, as discussed, is largely a UK health-care concept, similar ideas of being attentive to wider patient wellbeing are observable globally. The evidence does not suggest welfare concerns are well founded. Although we do not believe, given the extent of existing evidence, the onus is on providers to further show that remote care is adequate, additional data, including consideration of the long-term benefits or effects for women, could strengthen the case.

That said, early evidence from telemedical abortion provision in Great Britain suggests remote care better supports the wellbeing of women (including vulnerable women).[13–15,34] Consequently, telemedical services must continue after the pandemic. The success of telemedical abortion in Great Britain should serve as an example of a successful service delivery model for use elsewhere and in the future.[10]

Contributors

ECR contributed to the conception of the article and led the writing process of the manuscript. TH also contributed to the conception of the article. All authors contributed to drafting, revising, and approving the final version of the manuscript.

Declaration of interests

TH reports fellowship grant from Wellcome Trust. All other authors declare no competing interests.

References

1 Moreau C, Shankar M, Glasier A, Cameron S, Gemzell-Danielsson K. Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses. *BMJ Sex Reprod Health* 2020; published online Oct 22. https://doi.org/10.1136/bmjsrh-2020-200724.

2 Romanis EC, Parsons JA. Legal and policy responses to the delivery of abortion care during COVID-19. *Int J Gynecol Obstet* 2020; **151:** 479–86.

3 Parsons JA, Romanis EC. 2020 developments in the provision of early medical abortion by telemedicine in the UK. *Health Policy* 2020; **125:** 17–25.

4 Royal College of Obstetricians and Gynaecologists. Coronavirus (COVID-19) infection and abortion care. 2020. https://www.rcog.org.uk/globalassets/documents/guidelines/2020–07–31-coronavirus-covid-19-infection-and-abortion-care.pdf (accessed March 12, 2021).

5 US Food and Drug Administration. Questions and answers on Mifeprex. 2021. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex (accessed April 16, 2021).

6 Gibelin K, Agostini A, Marcot M, Piclet H, Bretelle F, Miquel L. COVID-19 impact in abortions' practice, a regional French evaluation. *J Gynecol Obstet Hum Reprod* 2021; **50:** 102038.

7 Slader S, Howson K. New Zealand's Abortion Law Reform. https://ohrh.law.ox.ac.uk/new-zealands-abortion-law-reform/ (accessed March 15, 2021).

8 Todd-Gher J, Shah P. Abortion in the context of COVID-19: a human rights imperative. *Sex Reprod Health Matters* 2020; **28:** 28–30.

9 Romanis EC, Parsons JA, Hodson N. COVID-19 and reproductive justice in Great Britain and the United States: ensuring access to abortion care during a pandemic. *J Law Biosci* 2020; **7:** lsaa027.

10 International Federation for Gynecology and Obstetrics. FIGO endorses the permanent adoption of telemedicine abortion services. 2021. https://www.figo.org/FIGO-endorses-telemedicine-abortion-services (accessed April 26, 2021).

11 Christian Concern. Tell the government not to extend DIY abortion policy. 2021. https://christianconcern.com/action/tell-the-government-not-to-extend-diy-abortion-policy/ (accessed April 16, 2021).

12 Endler M, Lavelanet A, Cleeve A, Ganatra B, Gomperts R, Gemzell-Danielsson K. Telemedicine for medical abortion: a systematic review. *BJOG* 2019; **126:** 1094–102.

13 Erlank CP, Lord J, Church K. Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes. *BMJ Sex Reprod Health* 2021; published online Feb 18. https://doi.org/10.1136/bmjsrh-2020-200954.

14 Aiken ARA, Lohr PA, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG* 2021; published online Feb 18. https://doi.org/10.1111/1471-0528.16668.

15 Reynolds-Wright JJ, Johnstone A, McCabe K, Evand E, Cameron S. Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic. *BMJ Sex Reprod Health* 2021; published online Feb 4. https://doi.org/10.1136/bmjsrh-2020-200976.

16 UK Parliament. Coronavirus Bill Volume 802: debated on Wednesday 25 March 2020. https://hansard.parliament.uk/Lords/2020-03-25/debates/3C266E78-4BB7-4330-9199-D361CDBAE2AD/CoronavirusBill (accessed April 16, 2021).

17 Care Quality Commission. Safeguarding people. 2019. https://www.cqc.org.uk/what-we-do/how-we-do-our-job/safeguarding-people (accessed April 16, 2021).

18 Love G. Abortion stigma, class and embodiment in neoliberal England. *Cult Health Sex* 2021; **23:** 317–32.

19 Department of Health and Social Care. Abortion statistics, England and Wales: 2019. 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf (accessed March 8, 2021).

20 UK Parliament. Abortion Act 1967. https://www.legislation.gov.uk/ukpga/1967/87/contents (accessed March 9, 2021).

21 Parliament of the United Kingdom. Care Act 2014. 2014. https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (accessed March 9, 2021).

22 Montgomery v Lanarkshire Health Board. [2015] UKSC 11. The Supreme Court; London, UK; March 11, 2015.

23 Herring J, Jackson E, Sheldon S. Would decriminalisation mean deregulation? In: Sheldon S, Wellings K, eds. Decriminalising abortion in the UK: what would it mean? Bristol: Policy Press, 2020: 57–76.

24 Royal College of Obstetricians and Gynaecologists. The care of women requesting induced abortion. 2011. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion/ (accessed March 12, 2021).

25 Aiken A, Guthrie K, Schellekens M, Trussell J, Gomperts R. Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. *Contraception* 2018; **97:** 177–83.

26 Othman S, Goddard C, Piterman L. Victims' barriers to discussing domestic violence in clinical consultations: a qualitative enquiry. *J Interpers Violence* 2013; **29:** 1497–513.

27 British Pregnancy Advisory Service. Pills by post: telemedical abortion at the British Pregnancy Advisory Service. 2020. https://www.bpas.org/media/3385/bpas-pills-by-post-service.pdf (accessed March 1, 2021).

28 MSI United Kingdom. 16.02.21: MSI UK reports increase in mental health concerns amid the coronavirus pandemic. 2021. https://www.msichoices.org.uk/news/media-enquiries/ (accessed April 15, 2021).

29 Weller S, Tippetts D, Weston D, Aldridge R, Ashby J, Richardson A. Increase in percentage of consultations disclosing domestic abuse (DA) in Integrated Sexual Health (ISH) services during Covid-19 'lockdown' following rapid transition to telemedicine and targeted interventions to improve delivery of routine enquiry. *Int J STD AIDS* 2020; **31** (suppl 12)**:** 1–114 (OL00I).

30 National Institute for Health and Care Excellence. Abortion care NICE guideline [NG140]. 2019. https://www.nice.org.uk/guidance/ng140/chapter/Recommendations (accessed March 11, 2021).

31 National Health Service. The NHS long term plan. 2019. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ (accessed March 12, 2021).

32 Cook J, Bewley S. Acknowledging a persistent truth: domestic violence in pregnancy. *J R Soc Med* 2008; **101:** 358–63.

33 Milne E. Banning safe home-use abortion pills will leave more women in crisis. 2021. https://theconversation.com/banning-safe-home-use-abortion-pills-will-leave-more-women-in-crisis-154594 (accessed March 12, 2021).

34 Aiken ARA, Starling J, Gomperts R, Scott J, Aiken C. Demand for self-managed online telemedicine in eight European countries during the COVID-19 pandemic: a regression discontinuity analysis. *BMJ Sex Reprod Health* 2021; published online Jan 11. https://doi.org/10.1136/bmjsrh-2020-200880.

© 2021 Elsevier Ltd. All rights reserved.