

Telemedical abortion care: Safeguarding Young People

Statement from the Royal College of Obstetricians & Gynaecologists (RCOG), the Faculty of Sexual and Reproductive Healthcare and the British Society of Abortion Care Providers (BSACP) regarding the advent of telemedical abortion care and the safeguarding of young people

1. Abortion is a safe and common procedure for women and girls around the world. No matter the gestation, abortion is safer than continuing the pregnancy to term. There is no evidence that abortion at any gestation results in poorer mental health outcomes than for women and girls who opt to continue their pregnancy¹. Self-managed abortion where the pregnancy is passed at home has been standard practice in abortion care in Great Britain for decades².
2. It is essential that young people receive the same quality and standards of care as all other patients when they access abortion services, including for telemedical care. This must be underpinned by reference to existing standards including Gillick competency²⁻⁴ and be evidence-based⁵⁻⁹.
3. Young people have particular needs and vulnerabilities, some of which can make attending face-to-face appointments at hospitals and licensed abortion providers difficult and ultimately result in barriers to accessing safe and legal abortion care.
4. Safeguarding assessments form an essential element of young people's abortion care, whether face-to-face or via telemedical means. Where abortion providers have concerns regarding safeguarding and/or the safety and wellbeing of young people resulting from telemedical care, patients may be asked to attend a face-to-face appointment as part of their care.
5. Abortion providers have extensive expertise and experience in the management of abortion care, of safeguarding and of the needs of vulnerable patients. They operate in one of the most highly regulated and legally proscribed areas of medicine. Existing systems for ensuring quality and learning are robust – including statutory requirements, licensing conditions of the Department of Health and Social Care¹⁰, intercollegiate guidelines on safeguarding children and young people¹¹, and regulation by the Care Quality Commission (CQC)¹² and other regulatory bodies.
6. As recognised in the recent NICE draft guideline on babies, children and young people's experience of healthcare¹³, young people have particular needs for privacy and confidentiality that must be respected and managed. It is essential that they can trust the system and feel safe engaging with healthcare providers. This is especially important for some groups, for example those at risk of honour-based violence. Young people may find it more difficult to attend healthcare facilities without breaching their confidentiality. Systems must enable them to consult with privacy without the need to inform a potential abuser. Remote access through telemedicine is therefore essential.
7. It is likely that young people will be able to talk more freely, and therefore be more willing to divulge intimate and distressing details, when they feel comfortable, safe and trust the provider. Providers have found that remote access is effective as young people are more able to build a rapport by telephone or social media link than they are when forced to attend what is often perceived as an intimidating and unfamiliar clinical environment.
8. Ultrasound is a useful medical tool, but its use for abortion care has never been required by clinical guidelines, regulation, or legislation in the UK, nor in many other countries, and its use is not recommended by NICE. It can be distressing and intrusive for patients requesting an abortion and compelling its use reinforces distrust which can damage the therapeutic relationship. Given clinical



evidence shows that it is not indicated for all abortion procedures, there are ethical considerations for providers if it were required to provide routine abortion care contingent upon ultrasound provision.

9. Roughly 7,500 patients under the age of 18 access legal abortions in England and Wales every year¹⁴. Abortion care must be provided in a way that best enables young people to access safe, legal care, and minimises the risk of them either seeking methods to end their pregnancy outside formal healthcare settings, or being forced to continue an unwanted pregnancy. Denying young people access to safe, legal telemedical abortion care will place barriers to access and have a negative impact on their health and wellbeing.

Background

In March 2020, the governments of England, Scotland, and Wales changed regulation to enable the administration of mifepristone for an Early Medical Abortion (prior to 10 weeks in England and Wales, and 12 weeks in Scotland) at home. This enabled the provision of telemedicine – with consultations provided by nurses, midwives, or doctors over video or telephone, and medications being received in the post.

In the first three months of this regime, 22,000 abortions in England and Wales were provided using this method – roughly 43% of all abortions during the period. Providers report that in the first year of operation, somewhere in the region of 75,000 early medical abortions have been provided using this method.

During this period, telemedicine has been available in principle to all abortion patients – with decisions made at individual patient level as to whether face-to-face consultation, scanning, or further tests are required. Blanket age restrictions are not a part of the legal regulation and have not been recommended by RCOG or BSACP.

Safeguarding is an essential element of abortion care. The experiences of providers are that the new pathways introduced in response to the COVID-19 pandemic¹⁵ have improved the quality of safeguarding. NICE had recommended telemedicine precisely because of good evidence that it improves access for vulnerable groups¹⁶, and now that at least 75,000 women and girls have accessed this care it is borne out by experience.

The experience of young people

Over 140 people under the age of 18 receive abortion care every week in England¹⁴ and there is a duty to ensure they can access the same quality of care as everybody else without barriers.

After detailed questioning and assessment by providers trained in safeguarding, the vast majority of young people who access abortion care do not need further safeguarding or referral. Many young people who present for abortion care do so in the context of an ongoing, consensual relationship. Assessing these young people for safeguarding concerns is essential, but ultimately only around 1 in 20 require a safeguarding referral.

Safeguarding

However, there is evidence that a shift to telemedicine has resulted in improved detection of those young people who do require further safeguarding involvement. Both major abortion providers have reported a more than 20% increase in the proportion of young people receiving a safeguarding referral since the introduction of telemedicine. One provider also reports a significant increase in the severity of the cases identified (52% of concerns identified required multi-agency referral after telemedicine was introduced compared to 24% when all were face-to-face) [MSI annual safeguarding report, 2021 in press].

Another major provider found that, when asked, 99% of clients said they were able to ‘find a private space, with no interruptions, for the duration of the telephone consultation’, 93% said they would have felt able to share any concerns regarding their safety at home or in a relationship, and 24% said that they had discussed such concerns with a member of the abortion provider’s team. Evidence from the UK

telemedicine programme found that no patients from a representative sample of 1243 women were unable to consult in private¹⁷.

Whilst some patients do prefer face-to-face consultations, more find it easier to divulge highly distressing and intimate details when they can do so confidentially and remotely, usually with greater privacy (not needing to rely on a parent or potential abuser for transport and with no fear of having to debrief them afterwards).

The need for continued access to telemedical abortion care

The sector feels strongly that the new pathway has delivered one of the biggest improvements in quality in a generation, and will benefit hundreds of thousands of patients every year. There is a strong evidence base that has now been peer-reviewed and published that demonstrates the new pathways are safe, effective and preferred by patients^{5 8 9 18}. The evidence demonstrates that access to abortion care has significantly improved, with reduced waiting times and gestation at abortion, even though most NHS services were severely restricted during this time.

There is evidence of a reduction in illicit sourcing of abortion care¹⁹, and that the most vulnerable groups who previously risked severe criminal sanction and bypassed NHS care are now able to access care from regulated providers with all the safeguarding and resources they offer.

It is essential that young people are not discriminated against and have access to the same quality of care and standards of safeguarding.

Supporting information

Changes to the early medical abortion pathway

Changes to clinical practice in all areas took place at pace following the introduction of the first lockdown of the pandemic and the associated pressures on the NHS and healthcare providers. Prior to the introduction of telemedicine, thousands of abortion appointments were cancelled, many clinics were forced to close as a result of staff sickness and PPE shortages, and patients were struggling to access transport to attend appointments. Patients who were shielding were unable to access any form of abortion care as home care was illegal.

Prior to the pandemic, the changes had already been recommended by NICE following a review of the literature, with NICE noting that telemedicine should be especially beneficial for vulnerable groups^{4 16}. Telemedicine and home use of abortion medication had also long formed a part of abortion care in other parts of the world.

Providers were acutely aware of the lack of ability to undertake pilots and began data-gathering immediately following the launch of the telemedical service. A full evaluation of the pathway change was conducted, resulting in the largest study to date in UK abortion care with 52,142 participants⁵. There was also another study that used different methodology but had identical results conducted in Scotland⁹. Taken together these studies provide compelling and definitive data.

Safeguarding processes were not significantly altered, as providers already had extensive expertise of delivering effective safeguarding via multiple routes including telephone assessment. However the impact of lockdown and the introduction of telemedicine is clearly demonstrated in the increased proportions of cases identified by providers. Whilst it is impossible to discern how much of this increase is attributable to the stresses of lockdown, and how much from better identification from telemedicine, there is no evidence that the new pathway has worsened identification of vulnerable patients.

Abortion care providers agree that the needs of young people are of paramount importance – both in providing high quality safeguarding services, and enabling young people to access the safe, legal, essential abortion care that they need.

Consultations via telemedicine

In some cases, it is easier for patients under coercive control to be able to speak privately if they can do so via telephone or internet link as they can choose a time when the abuser is away, or they can take action to be alone (e.g. speak from the bathroom or car). In contrast, if they have to attend an appointment they are likely to need to divulge the reason why they have to visit an abortion clinic. This is especially the case for young people who rely on others for transport and would be missed if they were absent from home or school.

Providers report that some of the most significant safeguarding cases have been identified via phone consultations, including honour-based violence, rape, and identification of a human trafficking ring.

Identification

In no field of medicine is proof of identity sought or required (other than gamete donation), and it is unclear why there is a presumption of dishonesty for women and young people seeking an abortion such that they should be seeking healthcare under false pretences. There is a wealth of evidence in support of telemedicine across many areas of medicine²⁰, but dishonesty is not raised as an issue in other sectors.

As recognised by – amongst others – the British Medical Association – the requirement of identity documents to access healthcare places providers in the invidious position of checking patients' immigration status and can dissuade patients who need care from presenting. As stated above, the additional privacy from a potential abuser that confidential remote access affords reduces the potential for exploitation by an abuser.

Requiring face-to-face for young people would pose a number of difficulties

We believe this suggestion to be disproportionate to the risk involved, and would prove discriminatory - denying young people, without evidence, access to the quality of care available to other groups solely on the basis of their age. It would also deny them privacy and best-practice safeguarding. It is likely to increase the risk of a young person failing to engage with healthcare services, with the worst outcomes being missed opportunities to identify abuse or a concealed pregnancy and birth.

Where ultrasound is performed, it is for a wider assessment than just detecting mid-trimester pregnancy and therefore any suggestion that young people have a scan solely for this indication would be inappropriate. However even if transvaginal ultrasound were deemed too invasive for young people, abdominal ultrasound can be distressing, intrusive and conveys distrust in the patient, especially given the accuracy of her dating is 99.96%⁵. There is no evidence that young people disproportionately need a scan to 'exclude mid trimester pregnancies'.

Our main concern is that it involves a mandated visit to a clinic or hospital which is likely to breach the young person's privacy and expose them to potential abuse, and it also introduces delay into the care pathway which is distressing and unnecessarily unkind.

Access to contraception

A discussion around and offer of long acting and reversible contraception is beneficial for many patients, and presentation for abortion gives the opportunity to organise that. This is a routine part of abortion care, and covered by the NICE guideline and quality standards.

There is no evidence that integrated contraceptive counselling increases the uptake of contraception as a whole, or long acting reversible contraception (LARC) – particularly given that intrauterine contraception cannot be fitted at the time of early medical abortion, and that patients are advised that injectables (e.g. DMPA) may reduce the success rates of early medical abortion. A study by one major provider found that telephone contraception counselling separate from abortion care may serve some women better than integrated counselling, including a higher rate of choosing and receiving a method of contraception, and providing a higher quality service for non-white women, those who had previously had difficulty accessing contraception, and those who had not been using contraception at the time of conception²¹.

Follow-up care for young people

Given that abortion care is so effective there is no need for routine follow-up, and NICE recommends that patients are offered self-assessment after medical abortion. The dominant emotion after abortion is relief, with no evidence of any emerging regret²², and most patients simply want to move on without further interference.

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