

Y Gymdeithas Feddygol Brydeinig
Pumed Llawr
2 Pentir Caspian
Ffordd Caspian
Bae Caerdydd
Caerdydd
CF10 4DQ

British Medical Association
Fifth Floor
2 Caspian Point
Caspian Way
Cardiff Bay
Cardiff
CF10 4DQ

BMA

Cymru Wales

Women and Children's Health Branch
Welsh Government
Cathays Park
CF10 3NQ

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Welsh Government consultation: Termination of Pregnancy arrangements in Wales Response by BMA Cymru Wales

Introduction

BMA Cymru Wales is pleased to provide a response to the consultation by the Welsh Government on regarding the termination of pregnancy arrangements in Wales.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Response

- 1. Do you consider that the temporary approval has had a positive impact on the provision of abortion services for women accessing these services with particular regard to safety, accessibility and convenience of services? Please provide your reasons.**

We believe it has had a positive impact. Data show that remote early medical abortion (EMA) provision, for eligible women, is both safe and effective. Remote provision has been shown to reduce waiting times, enabling abortion to take place at an earlier stage of pregnancy which is known to be safer. Remote EMA also improves accessibility for eligible women.

Cyfarwyddwr Cenedlaethol (Cymru)/National director (Wales):

Rachel Podolak

Cofrestrwyd yn Gwmni Cyfyngedig trwy Warant. Rhif Cofrestredig: 8848 Lloegr
Swyddfa gofrestredig: BMA House, Tavistock Square, Llundain, WC1H 9JP.
Rhestrwyd yn Undeb Llafur o dan Ddeddf Undebau Llafur a Chysylltiadau Llafur 1974.
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Registered office: BMA House, Tavistock Square, London, WC1H 9JP.
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This is also the view held by the main clinical bodies responsible for abortion care - the Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Healthcare (FSRH).

They also [state](#) that '*...while many healthcare services have paused during the pandemic, access to abortion has been not only maintained but improved through the innovative use of telemedicine. This has reduced unnecessary visits to clinics and increased the safety of abortion care.*'

As is currently the case, where there are additional considerations that may affect the safety of remote EMA, there will continue to be a need for face-to-face services for some patients. This is already provided for in the RCOG, Royal College of Midwives (RCM), FSRH and the British Society of Abortion Care Providers (BSACP) clinical guidelines that cover remote EMA, [Coronavirus \(COVID-19\) infection and abortion care](#).

- *Safer - reducing waiting times and consequently average gestation for EMA*

The earlier that an abortion is conducted, the safer it is - this is acknowledged in the [consultation document](#) itself 'Accessing EMA services rather than abortion later in pregnancy helps to reduce the risk of complications, which increases the later the gestation'.

The UK government [published 'provisional' statistics on](#) abortions performed in England and Wales during the COVID-19 pandemic from January to June 2020 (only for residents of England and Wales), which show that:

- 86% of abortions were performed at under 10 weeks compared with 81% during the same period in 2019.
- 50% of abortions were performed before 7 weeks' gestation compared to almost 40% for the same period in 2019.

No explanation for the reduction in the average gestation is given within the published statistics.

In addition, however, a study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA, using data from the three main abortion providers¹, show that the mean waiting time from referral to treatment was 4.2 days shorter in the telemedicine-hybrid model and more abortions were provided at ≤6 weeks' gestation (40% vs. 25%, p<0.001).

¹ Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. Accepted Author Manuscript. <https://doi.org/10.1111/1471-0528.16668> (<https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668>)

Following the [publication of 'provisional' statistics](#) by the UK government, two of the main abortion providers in England, MSI Reproductive Choices (formerly known as Marie Stopes) and BPAS, released some of the data from their services showing that:

- [MSI Reproductive Choices](#): 'Waiting times have significantly reduced, with almost half of patients (46%) able to have a detailed consultation with a clinician within one day, compared with 9% of non-telemedicine clients.'; and '56% of women [were] having their telemedicine abortion before 6 weeks compared to 37% previously. Lower gestational age reduces the already low complication rate of early medical abortion to 2.5%. Complications include retained products of conception (1.5%) and failed termination of pregnancy rate (1.0%) which can be treated by minor, planned procedures.' (MSI Reproductive Choices UK press statement. 10.09.20: *Abortion Statistics for England and Wales during the COVID-19 pandemic*).
- [BPAS](#): '...waiting times for appointments have more than halved, with an average wait for an appointment of just 4 days. The average gestation at which women have their consultation has also fallen by over a week, from 60 days in the first half of 2019, compared with 52 days during the same period in 2020.' (BPAS press statement 11.09.20: *Comment on DHSC Abortion Statistics: Telemedical abortion service results in significant drop in gestation at which women can access care – protecting their health during the pandemic*)
 - *Safer - supporting better access to regulated services*

For a range of logistical, social and economic reasons, individuals may illegally access abortifacients from unregulated suppliers, without the safety of knowing whether the drugs they receive are licensed and are what they claim to be.

The BMA has received feedback from doctors that they believe that some women who may have previously accessed abortifacients from unregulated suppliers are now accessing regulated safer abortions due to remote EMA provision.

This was recently highlighted by the English and Welsh Court of Appeal in the judicial review [R \(on the Application of Christian Concern\) v Secretary of State for Health And Social Care \[2020\] EWCA Civ 1239](#). In the judgment it noted evidence '*... which identify the risks to patients who were seeking EMAs in terms of their health and wider vulnerability ... vulnerable individuals were having to seek help from online providers, outside the regulated healthcare system, thereby breaking the law and losing the safeguarding and support inherent in the process provided by regulated services*' (at 48 of the judgment).

- *International*

Albeit not in the UK, remote EMA was already a tried and tested model for safe delivery of aspects of abortion services elsewhere.

The temporary approvals were introduced with the benefit of having patient outcome data from other countries which provided some form of remote provision of EMA prior to the pandemic - for example, [Australia](#) and [some states in the USA](#).

In addition, on the role of patients self-managing the process for medical abortion, the World Health Organization's (WHO) 2015 evidence-based guideline *Health worker roles in providing safe abortion care and post-abortion contraception*² recommends that, where individuals have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process, they can:

- safely and effectively self-manage mifepristone and misoprostol medication without direct supervision of a health-care provider.
- self-assess completeness of the abortion process using pregnancy tests and checklists.

The WHO guideline notes that *'Such self-assessment and self-management approaches can be empowering for women and help to triage care, leading to a more optimal use of health resources.'*

- *Accessibility*

Remote EMA improves accessibility for eligible patients. This was already recognised prior to the COVID pandemic. Separate to the actual treatment, aspects of abortion care could already be delivered remotely and were promoted by NICE as improving access to services.

The 2019 NICE guideline on abortion care notes, for example:

- *'1.1.9 Consider providing abortion assessments by phone or video call, for women who prefer this.'* [On this, [NICE found](#) *'Community services and telemedicine appointments are recommended because the evidence showed they improve access to abortion services. There was also limited evidence that patient satisfaction is the same with abortions provided by community or by hospital services, and with appointments provided via telemedicine or at the hospital'* (page 28)]; and
- *'1.14.1 For women who have had a medical abortion up to and including 10+0 weeks' gestation with expulsion at home, offer the choice of self-assessment, including remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up.'* [On this, [NICE found](#) *'Limited evidence was available showing no clinically important difference between remote and clinic follow-up for rates of adherence to follow-up.'* And *'There was only very limited indirect evidence on patient satisfaction, suggesting a preference for remote over clinic follow-up.'* (page 50)].

The benefits have been recognised by the clinical experts in the UK and also internationally. At the end of September 2020 the International Federation of Gynecology and Obstetrics (FIGO) [called for the strengthening of access to telemedicine/self-managed abortion](#) recognising that telemedicine is an effective tool that *'can ensure women and girls have access to safe, non-judgmental abortion services at all time[s]'*.

^{2 2} WHO (2015) *Health worker roles in providing safe abortion care and post-abortion contraception*
https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=154A2A05AC7427FB50EA554D1F5F3F78?sequence=1

- *Patient satisfaction*

In addition to safety and accessibility, patients' views of remote EMA should be considered, although likely to be affected by these other factors.

A study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA using data from the three main abortion providers in England³, shows that acceptability of telemedicine was high (96% satisfied) and 80% reported a future preference for telemedicine.

This chimes with other published data and feedback that the Welsh government has received from Chief Executives of health boards '*All have reported...very positive feedback from patients using this model of care.*' (pages 6-7 of the [consultation document](#)). For example, [MSI Reproductive Choices](#) found that '*98% of clients surveyed rat[ed] their experience as good or very good and 99.9%⁵ of clients report[ed] they had adequate privacy*'. Additional data from MSI found that '*Patients reported high confidence in telemedicine EMA and high satisfaction with the convenience, privacy and ease of managing their abortion at home. No patient reported that they were unable to consult privately. The majority (1035, 83%) of patients reported preferring the telemedicine pathway, with 824 (66%) indicating that they would choose telemedicine again if COVID-19 were no longer an issue.*'⁴

- *Access – intimidation and harassment outside services*

Remote access to EMA may also be more desirable and improve access for some patients who may be deterred from accessing healthcare due to anti-abortion demonstrations outside services. For example, ongoing activity outside Cardiff BPAS (<https://back-off.org/recorded-protests/>). Remote EMA is not, however, the solution to this problem, particularly as some women will still need to access services in person. We would be interested to hear what steps the Welsh Government is taking to address the issue of intimidation and harassment outside services as local responses are not adequate. The BMA believes that this issue needs addressing at a national level with the introduction of exclusion zones outside confidential abortion services. Only then can it be ensured that the harassment and intimidation can be stopped swiftly and straightforwardly, and no individual accessing services has to experience being filmed, shouted at, feel unsafe or be fearful and deterred from accessing healthcare.

2. Do you consider that the temporary measure has had a positive impact on the provision of abortion services for those involved with service delivery? This

³ Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), *Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study*. BJOG: Int J Obstet Gy. Accepted Author Manuscript. <https://doi.org/10.1111/1471-0528.16668> (<https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668>)

⁴ Porter Erlank C, Lord J, Church K. *Acceptability of no-test medical abortion provided via telemedicine: analysis of patient-reported outcomes* BMJ Sexual & Reproductive Health Published Online First: 18 February 2021. doi: 10.1136/bmjsex-2020-200954 (<https://srh.bmj.com/content/early/2021/02/17/bmjsex-2020-200954>)

might include greater workforce flexibility, efficiency of service delivery, value for money etc. Please provide your reasons.

We believe it has had a positive impact. The BMA has heard positive feedback from doctors who provide abortion services on the impact of remote EMA, primarily in the context of being able to provide choice and timely access to services for patients.

- *Workforce flexibility*

In addition, we have also received reports from our members that the temporary measures have enabled some doctors to continue working when they might not otherwise have been able to.

Many of the current doctors providing EMA have caring responsibilities and the ability to work from home allows for greater flexibility. For example, due to working time constraints as a consequence of opening hours of nurseries and schools and limited wrap around childcare.

Being able to provide remote EMA also helps in the retainment and recruitment of staff who may find it difficult to be in the clinical setting due to health reasons; logistical barriers such as long and costly commutes; work-life balance; and competing NHS commitments at other clinical sites.

Workforce flexibility broadens the group of doctors able to work for the service. Enabling doctors to provide some EMA remotely, and potentially over much larger geographical areas, will support much needed service efficiency, critical in the context of 'dwindling numbers of NHS healthcare professionals taking part in abortion care'.⁶

The British Society of Abortion Care Providers (BSACP) notes in its [position statement](#) on remote consultations 'Overall, studies on telemedicine in all its permutations and across settings are reassuring ... with respect to safety, complications and acceptability to patients and providers.' (The BSACP is a multi-professional organisation formed to promote, amongst other things, best practice and research in abortion care.)

- *Efficiency of service delivery*

Service providers will be best placed to respond on the efficiency of service delivery. Of note, however, a study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA⁵ shows that within the telemedicine-hybrid model, effectiveness was higher with telemedicine than in-person care (99.2% vs. 98.1%, p<0.001).

- *Value for money*

⁵ Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study. BJOG: Int J Obstet Gy. Accepted Author Manuscript. <https://doi.org/10.1111/1471-0528.16668> (<https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668>)

As noted previously, the introduction of remote EMA has brought down the average gestational age for an abortion. This potentially has financial implications as more patients may fall below certain gestational thresholds for treatment options. For example, prior to this, the [2019 NICE review of NHS workforce and resource impacts](#) noted:

- *‘A reduction in waiting times for an abortion. This will result in fewer surgical abortions overall and a corresponding increase in earlier medical abortions which have a lower tariff.*
- *‘An increase in earlier medical terminations may also lead to a reduction in outpatient appointments and diagnostic tests.*
- *‘A reduction in the number of women having rhesus status testing and anti-D prophylaxis.*
- *A reduction in the number of ultrasound scans.’*

3. What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

We are aware of several concerns about possible risks that have been raised since the implementation of the temporary provisions in England, Wales and Scotland. There have, for example, been tens of questions raised in the Westminster parliament since the remote provision was introduced, including questions on accurately establishing gestation and other safety concerns.

There have been some erroneous and factually incorrect reports of maternal deaths associated with the remote provision of EMA in England. The [UK government](#), the [RCOG and CQC](#) have, however, confirmed that there have been no maternal deaths as a consequence of remote provision.

We agree with the comment in the [consultation document](#) *‘We are confident that all clinical and safeguarding risks are being considered and managed appropriately including the assessment of gestation.’*

Abortion care is delivered within tight parameters outlined by law, regulation, clinical and professional standards. These are the same whether the service is delivered face-to-face or remotely – for example, the same standards regarding consent and safeguarding apply.

Of note, for example, on accurately dating a pregnancy, the [RCOG, RCM, FSRH and BSACP abortion COVID guidance](#) states:

- *‘Most women can determine the gestational age of their pregnancy with reasonable accuracy by LMP alone. A prospective trial of 4,484 women seeking early medical abortion found that 1.2% of women whose LMP dated them to less than 10 weeks had ultrasound dating of over 10 weeks. Inadvertent treatment of gestations over 10 weeks is inevitable in some women, although the consequences for most are unlikely to be significant*

Underestimation of gestational age could result in a failure of the abortion (the likelihood of which may be mitigated by offering additional doses of misoprostol – see section 2.4), and bleeding, cramping and distress being greater than expected. After 9 weeks, the products of the pregnancy may be more visible at the time of the abortion. Nevertheless, the overall success of self-managed abortions by women at >12 to 24 weeks' gestation is 93%, with efficacy and safety similar to that expected in earlier gestation.' (page 12)

- *'Where uncertainty exists, other factors in the woman's history may help to determine whether a scan ought to be discussed and considered – for example the timing of pregnancy testing and onset of pregnancy symptoms, dates that contraceptive pills were missed or when intercourse occurred.'* (page 13)
- *'There is no requirement for an ultrasound to determine gestation age in order for a doctor to authorise an abortion under the requirements of the Abortion Act 1967. There should be no legal consequences for either the clinician or the woman, even if gestation is unexpectedly advanced, when they can demonstrate that they have acted 'in good faith'. Data from the first 6 weeks of telemedicine suggests that the risk of inadvertently treating late gestations is low but given the high volume of cases, even low event rates will occur. It should be noted that terminations of pregnancy (of any gestation) carried out within the law are not subject to a child death review.'* (page 13)

- *The risks of not continuing to provide remote EMA*

The emphasis of this consultation is on the impact and/or risks of continuing this provision. Given the clear steer from clinical bodies directly involved in the provision of remote EMA that it is safe, there are no increased serious adverse events, and it should continue, it may be helpful to reframe the consultation and consider instead what the risks are of not providing a remote EMA service..

4. In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?

We are not aware of other NHS services being affected.

In terms of data on adverse events, there is nothing to suggest an additional burden on other NHS services. A study comparing outcomes before and after the implementation of the telemedicine-hybrid model of delivering EMA⁶ shows that treatment success (98.8% vs. 98.2%, $p > 0.999$), serious adverse events (0.02% vs. 0.04%, $p = 0.557$), and incidence of ectopic pregnancy (0.2% vs. 0.2%, $p = 0.796$) were not different between models.

Considering this more widely, the World Health Organization's (WHO) 2015 evidence-based guideline *Health worker roles in providing safe abortion care and post-abortion*

⁶ Aiken, A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J. (2021), Effectiveness, safety and acceptability of no - test medical abortion provided via telemedicine: a national cohort study. *BJOG: Int J Obstet Gy.* Accepted Author Manuscript. <https://doi.org/10.1111/1471-0528.16668> (<https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.16668>)

contraception⁷ notes that ‘Such self-assessment and self-management approaches can be empowering for women and help to triage care, leading to a more optimal use of health resources.’

5. Outside of the Covid-19 pandemic, do you consider there are benefits in relation to safeguarding and women's safety in requiring them to make at least one visit to a service to be assessed by a clinician? Please outline those benefits.

It is important that abortion services are able to identify, support and safeguard patients who are at risk. This is possible via telemedicine and via physical appointments.

A blanket requirement for patients to make at least one visit to a service may prevent some who are at risk from accessing regulated safe abortion services and safeguarding support – as was recently highlighted in the judicial review [R \(on the Application of Christian Concern\) v Secretary of State for Health And Social Care \[2020\] EWCA Civ 1239](#) ‘...vulnerable women were having to seek help from online providers, outside the regulated healthcare system, thereby breaking the law and losing the safeguarding and support inherent in the process provided by regulated services’ (at 48 of the judgment).

The [RCOG, RCM, FSRH and BSACP guidance](#) notes:

- ‘It is not known how many women access unregulated sources of abortion medication in the UK, but pathway modifications, following the approval of early medical abortion at home, make it likely this group will now access care through abortion care providers. The benefits of such vulnerable women engaging with abortion care providers are significant – the safeguarding processes may detect inaccurate dating of last menstrual period (LMP) and could identify victims of abuse who would otherwise have gone undetected’ (pages 8-9).

And later:

- ‘Safeguarding is an essential part of the assessment for abortion care, and providers should follow their processes and assess each case on an individual basis. However, there is no automatic need to have to do this in person if adequate assessment is possible via remote consultation, although it is recommended that this should be tailored to the individual. The clinician should be confident that the woman is not being coerced and that she is able to discuss any concerns privately. Remote consultation may enable vulnerable women, for example those with a coercive partner, to access care more discreetly, especially during COVID-19 and lockdown’ (page 24).

[MSI Reproductive Choices](#) data on this found that they had seen ‘...a 77% increase in the number of safeguarding cases identified’, meaning more protection for vulnerable women and girls who can now access help in private without the need to inform a

⁷ WHO (2015) *Health worker roles in providing safe abortion care and post-abortion contraception* https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=154A2A05AC7427FB50EA554D1F5F3F78?sequence=1

coercive partner or divulge intimate details to family.’ They also ‘*found safeguarding via telemedicine using a telephone or video consultation to be highly effective, as women and girls who are too frightened to attend consultations in person can talk more openly and privately. Safeguarding concerns identified have increased by 77% during the first six months of the COVID-19 pandemic and include major safeguarding cases such as a 12-year-old being subject to rape by two relatives.*’

BPAS has also reported that in the first three months of their [Pills by Post service](#), 10% of clients underwent an enhanced safeguarding risk assessment – a 12% increase compared to March 2020.

6. To what extent do you consider making permanent home use of both pills could have a differential impact on groups of people or communities? For example, what is the impact on people with a disability or on people from different ethnic or religious backgrounds?

We are aware of work currently being considered by the University of Liverpool to evaluate the positive and negative equity impacts of COVID-19 policy changes on access to EMA in England and Wales. If this work progresses, there may be insights which can be considered.

As alluded to elsewhere in our response, due to a range of logistical, social and economic reasons, women can find it challenging to access lawful abortion services: for example, for health reasons, juggling work and/or childcare commitments to attend appointments, and/or paying for travel if services are far away.

Current arrangements should not result in abortion services being delivered remotely exclusively – there will still be a need for face-to-face services where women and girls choose this or need them due to clinical and/or social factors - but any developments that broaden access to services should be welcomed and enhance access for different groups of women

7. To what extent do you consider that making permanent home use of both pills for EMA would increase or reduce the difference in access to abortion for people from more economically disadvantaged areas or between geographical areas with different levels of disadvantage?

Continuing the provision of remote EMA after the pandemic will help ensure that individuals from more deprived backgrounds, or between geographical areas with different levels of disadvantage, are able to continue to access safe lawful abortion services.

As [Evidence Review A](#) for the 2019 [NICE guideline](#) on abortion care notes:

'The committee agreed that the recommendations made (particularly those related to location of services, making it easier to access services and comorbid medical conditions) have the potential to reduce current inequalities in accessing abortion services for the following groups by improving referral pathways, minimising travel and decreasing the number of appointments that women need to attend in person: women living in remote areas, women with low income, women with comorbid physical and/or mental health problems, vulnerable women, and girls and younger women.' (page 46)

A recent study comparing the different responses by European countries to providing abortion in the pandemic notes *'some innovations including telemedicine deployed during the outbreak could serve as a catalyst to ensure continuity and equity of abortion care'*⁸

8. Should the temporary measure enabling home use of both pills for EMA:
 1. Become a permanent measure?
 2. Remain unaffected (i.e. be time limited for two years and end two years after the Coronavirus Act came into force (25 March 2022), or end on the day on which the temporary provision of the Coronavirus Act 2020 expire, whichever is earlier).
 3. Other [please provide details]?

The BMA supports making these temporary changes permanent so that eligible individuals who choose can continue to access EMA remotely after the COVID-19 pandemic. This position was formally adopted at the BMA's annual representative meeting (ARM) in September 2020 when the benefits and risks of continuing current arrangements were debated by the BMA's policy-making representative body.

Remote EMAs should become a permanent option where clinically appropriate. They reduce waiting times, allowing abortions to take place at an earlier stage of pregnancy, which is safer; they improve access; and patients report high levels of patient satisfaction.

It is the BMA's view that continuation of this arrangement is in line with best global practice and benefits patients, particularly those at risk of domestic violence.

We believe that this view is also supported by the feedback that Welsh Government officials have received from Chief Executives of health boards 'All have reported improved outcomes in a number of areas including shorter waiting times, increased numbers of abortions taking place at a lower gestation and, significantly, very positive feedback from patients using this model of care. There have also been positive outcomes in terms of better use of resources and cost effectiveness' (pages 6-7 of the [consultation document](#)).

⁸ (Moreau C, Shankar M, Glasier A, et al. Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses. *BMJ Sexual & Reproductive Health*. Available at <https://srh.bmj.com/content/early/2021/01/13/bmjshr-2020-200724>).