Briefing re: telemedicine abortion beyond COVID-19

Date	26.1.2022
Title	Briefing re: telemedicine beyond COVID-19
Content	The purpose of this document is to summarise the main reasoning behind the consensus that offering the option of telemedicine is best practice in abortion care, regardless of COVID-19.

Since the government permitted telemedicine abortion in March 2020, the service has been a success. It has reduced waiting times, brought down the average gestation at which abortion is carried out, and allowed clinicians to make the safest decisions for the individual, instead of forcing everyone to follow a one-size-fits-all model.

This briefing sets out the main reasons why offering the option of telemedicine for early gestations, where it is safe and clinically appropriate, is regarded as best practice by experts around the world, regardless of whether there is a global pandemic.

- **Offering telemedicine has long been recognised as best practice**
- **Flexibility and patient choice are core principles beyond COVID-19**
- **Telemedicine is about offering more options, not changing the pathway for all**

1. Offering telemedicine has long been recognised as best practice

1.1 Offering an option of accessing abortion by telemedicine is the recommended best practice for abortion care, irrespective of COVID-19.

1.2 While the pandemic may have been the main driver for the government in permitting telemedicine for abortion, providers, regulators, guidance bodies, researchers and clinicians have always been clear that forcing every single person seeking an abortion into a clinic to take abortion medication, regardless of personal, emotional, or clinical circumstances, is poor practice, and should not happen.

1.3 The National Institute for Clinical Excellence (NICE) has recommended offering the option of telemedicine abortion long before the pandemic.

1.4 During the period that telemedicine services have been delivered, further information, evidence and experience has been gathered. The success of the service can be seen in the fact that trusted bodies including NICE, the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and the British Medical Association (BMA) all continue to recommend telemedicine as best practice, regardless of the pandemic.

1.5 The World Health Organisation (WHO) has published recommendations on self-care which support “self-managed abortion” (telemedicine), irrespective of the pandemic. The WHO describes “self-managed abortion” as “safe, feasible, and effective”, and recommends in general that “existing national sexual and reproductive health policies should be adapted, developed, and/or harmonised to include abortion-related self-care interventions.”[1]

1.6 In the USA, the Food and Drug Administration (FDA) approved postal provision of mifepristone at a federal level in 2020. On 16 December 2021 they made this provision permanent.

1.7 In addition to clinical experts, organisations such as Women’s Aid, Rape Crisis, and the End Violence Against Women Coalition support keeping the option of telemedicine[2] as it is a necessary

[1] WHO-SRH-20.11-eng.pdf
[2] telemedical-abortion-care-open-letter-updated.pdf (bpas.org)

part of protecting women and girls from domestic abuse, so-called honour violence, and reproductive coercion.[3]

1.8 It is necessary in many serious safeguarding cases that everyone involved has the flexibility to ensure the safest pathway for that particular individual is always followed. For example, some women in abusive partnerships are unable to safely attend a clinic in person. If a medical consultation concludes that telemedicine is the most clinically appropriate pathway, and a safeguarding expert concludes that telemedicine is the safest pathway, it is unjustifiably dangerous to remove that pathway.

2. Flexibility and patient choice are core principles beyond COVID-19

2.1 As we learn to live with this pandemic, and indeed, possibly others in future, we need to ensure that resilience is built into our health and care services, including abortion.

2.2 Pandemics are only one example of why resilient services are needed. There are wider changes necessary regarding the way the health and social care system operates. As the Health and Social Care Bill sets out, these necessary improvements are driven by principles such as keeping the patient at the centre of service design, strengthening patient choice, joining up care in an efficient way which avoids duplication or unnecessary activity, using resources as cost-effectively as possible, and delivering outcomes closer to home. As there is no clinical or safeguarding reason why abortion medication must be taken in a clinical setting, forcing providers to operate otherwise is remarkably inefficient, short-sighted, and flies in the face of these principles.

2.3 In November last year, the Secretary of State for Health and Social Care told the House of Commons Health and Social Care Select Committee that the matter of face-to-face versus remote access (for primary care) should be "about choice," rather than a target for activity delivered via either model, or a one size fits all model.[4] There is no reason why abortion services should be exempt from this principle, especially when telemedicine has been delivered effectively and is preferred by a majority of women accessing the service.[5]

3. Telemedicine is about offering more options, not changing the pathway for all

3.1 Telemedicine is an option which is available on the basis of clinical eligibility, and choice. It is not the only pathway, and nor do we advocate that it should be.

3.2 Service users can still choose to attend clinics. At least 50% of service users across all Independent Sector Providers (ISPs) opt to attend a clinic for face-to-face care.

3.3 Service users can visit and revisit clinics for counselling, aftercare and follow-up, and contraceptive appointments if they choose. In many respects, the service itself is largely unchanged; the most significant difference is whether both the mifepristone pill and the misoprostol pill can be taken at home, or whether only the misoprostol should be permitted for home use.
3.4 Two separate studies have found that service users value having the option of telemedicine and found it easier to access care via telemedicine.[6] [7] To remove this option for all, when having the choice is so highly valued, is indefensible.

---

[3] msi-uk-submission-vawg-strategy.pdf (msichoices.org.uk)
[4] "It is not about a number. It is about doing the right thing. Ultimately, it is about choice for the patient." Secretary of State for Health and Social Care Sajid Javid, Hansard, 2 November 2022
[5] "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." bmj-srh-msi-uk-acceptability-of-no-test-medical-abortion-provided-via-telemedicine.pdf (msichoices.org.uk)
[6] bmj-srh-msi-uk-acceptability-of-no-test-medical-abortion-provided-via-telemedicine.pdf (msichoices.org.uk)
[7] Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study - Aiken - 2021 - BJOG: An International Journal of Obstetrics & Gynaecology - Wiley Online Library