Safeguarding and Teleconsultation for Abortion

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 in late March 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 (OECD) countries have also temporarily amended policies to enable remote consultation and at-home use of abortion medications: France,[1,2] Ireland,[1] and the US[5] (see **Table 1)**. Others have enabled fewer face-to-face consultations, though abortion medications must still be collected or administered in-person - for example, Estonia and Germany.[1] In the majority of OECD countries, however, laws continue to prohibit *fully* remote abortion provision.

There have been calls internationally to make enable remote provision where it is not yet available.[7] Where a change has occurred - for example in Great Britain - this has, arguably, resulted in clinically and ethically superior care,[6] spurring calls for telemedical abortion to become standard practice.[2,6] The International Federation of Gynecology and Obstetrics 'recommends investment by governments around the world to strengthen the provision of and access to telemedicine.'[8] Public consultations about making permanent changes to the law in Great Britain to allow telemedical abortion have recently closed.

Most objections to telemedical abortion by politicians and anti-abortion groups relate to women's safety, suggesting it is less safe for the medication to be administered at home and that adequate safeguarding by healthcare professionals (HCPs) is limited.[9] A growing body of evidence demonstrates that remote abortion care is at least as safe, effective, and acceptable to patients as face-to-face care,[10,11,12,13] 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… abortion by an abusive partner'.[14] In UK healthcare, safeguarding is the protection of vulnerable people's health, wellbeing, and human rights. England's Care Quality Commission recognises safeguarding as 'an integral part of providing high-quality health care'.[15] In practice, safeguarding requires HCPs to consider the broader wellbeing of patient's beyond the matter they are seeking care for, including, for example, addressing concerns about harm reduction outside of a healthcare 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 who consider safeguarding through remote care inferior, and that remote abortion care should remain lawful in the absence of compelling data to suggest otherwise.

Before addressing the adequacy of remote safeguarding, it should be noted that the very fact that safeguarding is being centred in the discourse around telemedical abortion reiterates problematic notions about women seeking to end unwanted pregnancies as being inherently vulnerable and in need of institutional support. It also implies that safeguarding affects a substantial proportion of patients. Such inferences perpetuate harmful abortion stigma in attempting to "justify" why women need abortions,[16] rather than accepting that it is routine, essential healthcare. Abortion *is* routine healthcare in the UK (there were 207,384 abortions in England and Wales in 2019).[17] There is therefore also the matter of proportionality. Safeguarding processes certainly need to adapt to remote provision, but there is no evidence, we argue, to suggest this cannot be satisfactorily achieved. Even if one disagrees that remote abortion care may benefit the vulnerable minority, this does not mean we should not offer this service when there are substantial benefits for the majority.[6, 12]

The Abortion Act 1967 requires that two doctors be satisfied that a woman meets the "social ground" for abortion before care is provided, but does not mandate that safeguarding be undertaken with vulnerable women before care is provided. However, healthcare regulators require adequate safeguarding processes and HCPs have legal obligations to protect patients from harm.[18] Lawful medical treatment (including abortion) requires the capacitous patient's informed consent,[17] which must be given voluntarily.[20] HCPs 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 HCPs providing abortion care identify patients who may require additional safeguarding support, potentially including 'young women, those with a pre-existing mental health condition, those who are subject to sexual violence or poor social support, or where there is evidence of coercion'.[21] Voluntary consent might be thought 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 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. 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.[22] The reality is that, without remote provision, many of the patients needing additional support do not have any contact with a HCP in having their abortion. Even where 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.[23] While an abuser may actively interfere by coaching a patient during a phone call, their control over their victim may remain during an in-person clinic visit when they are not there, for example, because the threat can still feel imminent to the victim. A patient is more likely to disclose if they are confident that their abuser is unaware, which may be easier if remote consultation is available – it is difficult to keep secret a trip to the clinic, whereas a remote consultation may 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 conducted over the phone. The UK's two main abortion providers have reported an increase in enhanced safeguarding referrals since the introduction of remote care.[24, 25] There are many reasons why some women may find attending a clinic or hospital intimidating – potentially because they anticipate an intrusive examination and/or being judged. Consequently, remote care could sometimes *increase* the likelihood of disclosure, and therefore telemedical services remaining after the pandemic may be beneficial for vulnerable women in terms of increasing the likelihood of them receiving adequate assistance where necessary. Patients can discuss their treatment with a HCP in a comfortable, familiar environment, resulting in heightened engagement with the consultation. Some patients have reported finding it easier to disclose intimate information and/or abuse in *remote* sexual health consultations.[26] If a patient is concerned about being seen attending a clinic, making an excuse to leave their home, or breaking with usual routines, they may be less anxious during a remote consultation. Their home might also be a space (or they may 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 will not be universally true, but it is foreseeable that some patients will be more likely to disclose when not in an intimidating clinical environment. Further, it remains within clinical discretion for the consulting HCP to insist on an in-person appointment if 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 consultation.

Finally, 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, which recommended in 2019 that, for women who prefer it, abortion assessments can take place by phone/video call.[27] Remote consultation is becoming more prevalent in most specialties given the NHS Long Term Plan, compounding the importance of ensuring that HCPs are trained in, equipped for, and confident with remote communication.

Finally, irrespective of the extent to which a safeguarding assessment can be considered adequately when conducted 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.[6, 22] 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.[3,6] The urgency is often heightened for women experiencing intimate partner violence – not only to end an unwanted pregnancy, but also to prevent the evidenced increase in such violence during pregnancy.[28] Without the option to access this care remotely, many vulnerable women seek it unlawfully by purchasing abortion medications online,[22, 29] 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 we were to consider in-person care the ideal, remote provision results in fewer women having no access to care or accessing care unlawfully. This has been found to be the case in Great Britain since the change in regulations, whilst use of unregulated, online abortion services has increased in countries where access to abortion was not secured during the COVID-19 pandemic.[30] In enabling these women to access care through regulated healthcare services, remote care affords them access to quality care alongside an appropriate standard of safeguarding support.[4,30] 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 conducted adequately during remote consultations, but the underlying assumption that safeguarding concerns should prevent the permanence of this service is problematic. Whilst safeguarding as discussed is largely a UK healthcare concept, similar ideas of being attentive to wider patient wellbeing are observable globally. The evidence does not suggest welfare concerns are well-founded. Whilst we do not believe, given the extent of existing evidence, the onus is on providers to further demonstrate that remote care is adequate, additional data, including consideration of the long-term benefits or impacts for women, could strengthen the case.

That said, early evidence from telemedical abortion provision in Great Britain suggests it better supports the wellbeing of women (including vulnerable women).[11,12,13,30] 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 into the future.[8]

Table 1. OECD countries that made changes to law/policy to enable *fully* remote abortion care in response to COVID-19

Country	Change
France	National Health Agency Guidelines issued in April 2020 stipulating that abortion by telemedicine would be temporarily permissible. Gestational limit on home use of abortion medications raised to nine weeks.
Great Britain	Approval orders issued by Health Ministers in England, Wales, and Scotland in March 2020 amended the law to enable fully remote abortion. 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 they would be revoked. Remote abortion temporarily permissible until nine weeks and six days in England and Wales, and a recommended limit of 11 weeks and six days in Scotland.
Ireland	Department of Health issued new guidance in April 2020 enabling remote consultation and home use of abortion medications until nine weeks' gestation.
New Zealand	*Abortion was decriminalised in New Zealand in March 2020, meaning that there are now no criminal restrictions on abortions provided by healthcare professionals before 20 weeks' gestation.* *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 actions of some District Health Boards to quickly make changes in April 2020 to enable telemedical abortion was.*
United States (US)	Food and Drug Administration announced in April 2021 that they would cease enforcement of the mandatory in-person dispensing requirement for mifepristone during the pandemic. This 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.

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