Consultation on Future Arrangements for Early Medical Abortion at Home

RESPONDENT INFORMATION FORM

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Are you responding as an individual or an organisation?

☐ Individual

☒ Organisation

Full name or organisation's name

The Free Church of Scotland

Phone number 0131 226 5286

Address

Free Church of Scotland, 15 North Bank Street, The Mound, Edinburgh

Postcode EH1 2LS

Email offices@freechurch.org

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We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

☒ Yes

☐ No

If you wish to respond to this consultation by email or by post please provide your responses and any comments on the next page.

Consultation Questions

Where options are given please check or add a cross in the box next to the option which most reflects your views.

Question 1. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had on **women accessing abortion services**? Please answer with regards to the following criteria:

a) **safety**

☐ No impact

☐ Positive impact

☒ Negative impact

☐ The impacts are mixed

b) **accessibility and convenience of services**

☐ No impact

☐ Positive impact

☐ Negative impact

☐ The impacts are mixed

☒ I don't know

c) **waiting times**

☐ No impact

☐ Positive impact

☐ Negative impact

☐ The impacts are mixed

☒ I don't know

Comments (optional):

The decision of whether or not to have an abortion is already one of the most serious decisions a woman can make during her lifetime. There are serious long term consequences of a woman deciding to go ahead with an abortion. From pastoral experience we know that many women who underwent an abortion years ago still suffer trauma and grief associated with that decision. Organisations that offer post-termination counselling often encounter women who underwent abortions years ago (in some cases 10 or 20 years ago) who are still dealing with the psychological impact. Trauma can often be associated with a place where the event happened – so where a woman carries out the abortion at home the traumatic experience can become associated with her home – which can result in her safe place no longer feeling safe.

Thus, any decision about a possible termination must be done only after appropriate face to face counselling with a healthcare professional. It is vital that this counselling is of a very high standard, providing as much information as possible with alternative options. Physicians and Counsellors know how important it is to see someone face to face when making such decisions. Phone calls or video calls, are completely inadequate for the level of care required in this sensitive area. The healthcare professional and the woman need to be able to discuss the options in a relational and non-judgmental way that gives proper respect to the person making the decision and allows space for reflection.

Significant risks for the woman exist in the greater use of home abortions including:

1. The possible existence of undue pressure

Coercion and undue pressure are common issues connected with a woman seeking an abortion[1]. This can come both from the child's father but also often from other people such as the woman's mother. There can also be pressure from other third parties especially where the woman is caught up in prostitution or human trafficking. We also know that the Coronavirus pandemic has resulted in increased reports of domestic abuse[2].

GPs and other healthcare professionals are trained to identify the signs of such coercion or undue pressure. In a face-to-face consultation it is easier for the woman to speak freely without the coercing party being there or listening in. The healthcare professional can also offer alternatives to the woman or other support where she does want to keep the child. With a video consultation a third party can be lurking off camera and continuing to apply pressure to the woman, with the health care professional having no way of knowing this.

A face-to-face consultation is also more relational, which makes it more likely a woman will feel able to speak out about abuse. Bad internet or other technical issues make video calls inherently less personal and it can take a lot longer to build up a trusting relationship.

2. Misunderstanding of the psychological risks of having an abortion

There are significant long term psychological risks already associated with abortion but a home abortion amplifies these risks[3]. The lack of physician involvement puts a

[1] See Hathaway J E, Willis G, Zimmer B, Silverman J G, "Impact of partner abuse on women's reproductive lives" *Journal of the American Women's Medical Association* 60 (2005), 42-45; Chibber KS et al, "The role of intimate partners in women's reasons for seeking abortion", *Women's Health Issues* 24 (2014), e131–38.

[2] www.bbc.co.uk/news/uk-52157620

[3] There is a lack of good research into the psychological risks associated with abortion and more work needs to be done. See David C Reardon, "The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research Opportunities". SAGE Open Medicine 2018(6), 1-38 and Edna M. Astbury-Ward, "Emotional and psychological impact of abortion: a critique". J Fam Plann Reprod Health Care 2008: 34(3), 181-184. See also "Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors" (https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf) which states: "An unwanted pregnancy was associated with an increased risk of mental health problems." and the authors recommend

greater proportion of responsibility directly on the woman which could increase later experiences of trauma. Any underlying psychological issues can be exacerbated by the lack of psychological assessment provided by phone/video calls, and the additional ordeal of undergoing the procedure at home.

It is also possible she will be entirely alone when she takes the pills – it is possible she would wish to remain entirely anonymous and so would not tell anyone what she was doing resulting in no emotional support. She may not fully understand the potential trauma of undertaking the procedure, alone, at home. It is an unpleasant and potentially painful experience. She may unintentionally see the embryo / foetus that she has to then dispose of down the toilet which again can be very traumatic without support.

Additionally, the fact that the procedure was carried out in the woman's home may mean any trauma becomes associated with the home and can be triggered by the woman constantly being reminded of her experience in her home.

Thus, having a home abortion may significantly increase the risks of psychological trauma and feeling of loneliness for the woman. This means that compassion should be shown to such women who should always be offered counselling to cope with the upset. Funding should be made available for various organisations which provide post termination counselling. Information on where to go for emotional support should also be provided.

3. Misunderstanding of the medical risks involved

Another danger is that the woman may not fully understand the medical risks involved - significant bleeding and sepsis are not uncommon. Where a woman is completely alone, she may not have any support for dealing with any complications. Whilst the evidence is that serious complications are uncommon, it is possible and therefore it is inherently less safe to allow abortions to be conducted at home with no support. It is obvious that the risk of medical complications increases in unsupervised abortions.

It is also questionable whether informed consent is really being obtained over a telephone / video call. This is especially true where some women may not speak English as a first language. It is easier to tell in a face-to-face consultation whether the woman really understands the implications of the procedure.

4. Misuse of the abortion pills

A significant risk may exist that the woman does not adhere to the precise time intervals between taking the two drugs for home abortions. Taking the second drug incorrectly increases complications for the woman who may even require surgery.

The woman may continue to wrestle with doubts regarding the abortion and therefore delay taking the pills. Or it is possible that, without a medical examination, the presumed gestation may be wrong, and the woman may receive the pills for a

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that "In the light of these findings, it is important to consider the need for support and care for all women who have an unwanted pregnancy because the risk of mental health problems increases whatever the pregnancy outcome."

pregnancy that is over 10 weeks gestation. There is a reported case from 2020 of a woman at 28 weeks gestation taking the pills and delivering a baby which subsequently died[4].

Moreover, some women may abuse the system and obtain the pills for someone else. The self-administration of abortion pills removes any control over who takes the pills, where they are taken, whether they are taken, when in the pregnancy they are taken, and in the case of underage patients, whether an adult is present. It is not clear how healthcare professional can ensure the pills are taken by the individual they are provided to and within the appropriate time frame.

5. Possibility of regret after taking the first pill

Some women may regret taking the first pill – GPs receive requests for abortion reversal after women have taken the first pill (mifepristone). Abortion is a significant and difficult decision and often women harbour doubts about their actions.

The right to withdraw consent is an integral part of the principle of informed consent so women should be able to stop an abortion procedure, after a reflection and cooling off period. This may mean that progesterone pills which can reverse the effects of mifepristone should be provided with the other drugs to take home. Indeed, the effects of mifepristone (which works as an antagonist of progesterone - a hormone essential for a successful pregnancy) can be counteracted by quickly giving the woman large and repeated doses of progesterone, by mouth, vaginally, or by injection, every day until the end of the first trimester (that is about 14 weeks). But it is a race against the clock – the reversal procedure must be started no later than 48 hours after the mifepristone pill has been taken.

It is also not always clear what happens where the woman only takes the first pill. There are reports that about 30% to 50% of women who take mifepristone alone will continue to be pregnant[5]. However, it should also be noted that embryonic and foetal development effects such as clubfoot, limb and cranial nerve abnormalities have been reported in pregnancies that continue to birth following the taking of mifepristone[6]. So a great deal of harm may be done to the child when they are born.

For all of these reasons we believe home abortions are inherently unsafe to women and should not be permitted.

Question 2. What impact do you think that the current arrangements for early medical abortion at home (put in place due to COVID-19), have had for **those involved in delivering abortion services**? (For example, this could include impacts on workforce flexibility and service efficiency.)

[4] See https://www.thesun.co.uk/news/11690506/police-probe-death-of-unborn-baby-after-woman-has-illegal-abortion-by-post-at-28-weeks-four-weeks-past-limit/ & https://www.dailymail.co.uk/news/article-8349739/Police-investigate-death-unborn-baby-woman-took-abortion-drugs-home-28-weeks-pregnant.html

[5] Shannon Firth, Reversing Abortion Pill: Can It Be Done?, MedPage Today, 24 February 2015, https://www.medpagetoday.com/obgyn/generalobgyn/50164

[6] See: http://www.misoprostol.org/misoprostol-teratogenicity/

☐ No impact

☐ Positive impact

☒ Negative impact

☐ The impacts are mixed

☐ I don't know

Comments (optional):

The current arrangements for home abortions may result in the following negative consequences for those involved in delivering of abortion services:

1. Misunderstanding woman's intention

If the only communication is via telephone or video call the physician may not fully understand the woman's concerns and intentions. This can be complicated where the woman does not speak English as a first language. A face-to-face consultation is far superior for the healthcare professional to know the woman has fully understand the procedure and that they have understood the women's intentions.

2. Compassion and Empathy for Woman are difficult to communicate via calls

Sensitive topics are always better discussed in person. Telephone and video calls do not allow compassion and empathy to be clearly communicated. Healthcare professionals care deeply for their patient's wellbeing and want what is best for them. It is not adequate to simply have a short video call with a woman considering abortion who may already be feeling extreme pressure.

3. Difficult to determine the stage of pregnancy

Usually where a woman is considering an abortion a scan would be conducted to determine the stage of the pregnancy. But this is not always the case with home abortions which may result in mistakes being made – with higher risks to women who are prescribed abortion pills after the 10-week limit.

4. Difficult to ensure appropriate informed consent

Healthcare professionals need to assess age, mental ability and any possibility of undue pressure or coercion when a women is considering abortion. This is incredibly difficult when making use of either telephone or video calls. A face-to-face consultation is the only appropriate way to assess such complex issues.

5. Impact of complications on the physician

The physician has a duty of care to the woman and healthcare professionals take this very seriously. How then will they feel when there is a complication? Surely, they will know that they could have offered better care through a face-to-face consultation and so will have increased feelings of regret and responsibility for their part in the procedure.

For all of these reasons we believe home abortions inherently have a negative impact on the ability of healthcare professionals to show due care to women considering an abortion and so home abortions should not be permitted.

Question 3. What risks do you consider are associated with the current arrangements for early medical abortion at home (put in place due to COVID-19)? How could these risks be mitigated?

Comments:

We have already made clear in our answers to questions 1 and 2 that there are a number of serious risks association with the current arrangements for early medical abortion at home including:

1. The possible existence of undue pressure
2. Woman misunderstanding the psychological risks of having an abortion
3. Woman misunderstanding the medical risks involved in having an abortion
4. Misuse of the abortion pills
5. Possibility of regret after taking the first pill leading to potential medical complications
6. Healthcare professionals misunderstanding woman's intention and giving the wrong advice
7. Lack of compassion and empathy expressed for Woman via telephone or video calls
8. The difficulty in determining the stage of pregnancy with the potential for greater complications.
9. The difficulty of ensure appropriate informed consent.
10. The impact of complications on the physician's wellbeing.

In our view these increased risks associated with home abortions cannot be mitigated and therefore it is inappropriate to persist with making more arrangements for home abortions.

Question 4. Do you have any views on the potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) **on equalities groups (the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation)?**

☒ Yes

☐ No

☐ I don't know

If yes, please outline possible impacts below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

Comments:

Appropriate informed consent should always be given by a person wanting an abortion. This will inform the individual of the possible risks and ensure the person is capable of understanding the nature of such a life and death decision. Appropriate informed consent requires an assessment of the person's capacity to make the decision and membership of various protected groups can impact someone's ability to offer informed consent.

Under 18-year olds may wish an abortion without their parents finding out and this is currently legal. However, it is unlikely that girls under 18 years of age can fully understand the implication of the momentous life and death decisions associated with abortions. It is better to assess this in a face-to-face consultation to ensure appropriate informed consent.

Greater care also must be taken to ensure that mentally disabled women give informed consent. Again it is essential that any consultation takes place face-to-face to ensure informed consent.

It is also possible that some women do not speak good English and that might not become clear in a telephone / video call. It is essential that they are met in person to ensure understanding and informed consent. Where a woman who does not speak good English is also subject to abuse or coercion it is likely the abuser becomes the translator in a telephone or video call which is entirely inappropriate. Clinics are able to provide their own translators to help expose issues of coercion.

Question 5. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) **on socio-economic equality?**

☒ Yes

☐ No

☐ I don't know

If yes, please outline possible impacts below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

Comments:

A disproportionately high number of abortion requests coming from those living in poverty. More support should be provided to help women from these backgrounds understand their options and receive support to keep the child. A healthcare professional setting is a better place for such help and support to be provided.

Question 6. Do you have any views on potential impacts of continuing the current arrangements for early medical abortion at home (put in place due to COVID-19) on **women living in rural or island communities?**

☒ Yes

☐ No

☐ I don't know

If yes, please outline possible impacts below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

Comments:

Women living in rural or island communities live a greater distance away from A&E departments which may make home abortions inherently unsuitable. Where there are medical complications it is vital that women can make it to an A&E department within 30 minutes to receive appropriate treatment. This is not possible for those in more rural communities and accordingly the risks of serious complications with the inability to receive appropriate medical care are too great and home abortions should not be permitted.

Question 7. How should early medical abortion be provided in future, when COVID-19 is no longer a significant risk? [select one of the options below]

☐ a) Current arrangements (put in place due to COVID-19) should continue – in other words allowing women to proceed without an in person appointment and take mifepristone at home, where this is clinically appropriate.

☐ b) Previous arrangements should be reinstated – in other words women would be required to take mifepristone in a clinic, but could still take misoprostol at home where this is clinically appropriate.

☒ c) Other (please provide details)

For all the reasons we have outlined in our response abortions at home are inherently less safe and open to abuse. It is not possible to mitigate these many risks and accordingly, home abortion is not appropriate. It is noteworthy that when the Abortion Act 1967 was introduced in the UK it was to protect women from the risks associated with abortions away from a health care setting. The move towards home abortions is therefore a backwards step introducing increased risks to women who deserve the best possible care which requires face-to-face contact.

As Christians we believe all human beings have inherent worth and value, having been made in the image of God. We also believe it is right for the church to speak up on issues such as abortion provision and to strive for a more just society. Proverbs 31:8-9 tells us to “Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy.” As a church we are concerned for the rights of the unborn child and believe more needs to be done to protect the child in the womb. We do not therefore share the State’s view as to when abortion is permissible; indeed, we believe that there are few

circumstances in which it is justified. Although we recognise that is beyond the scope of this consultation. Whether one approaches the question of abortion from the point of view of the rights of the woman or the rights of the unborn child, we are also deeply concerned for the health and wellbeing of any woman who finds herself considering abortion or having to self-administer abortion in her home. We want processes that show compassion to women in these circumstances and which protect them from the huge medical risks inherent in these proposals.