Termination of pregnancy arrangements in Wales

Q1: 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.

Overall no. While the temporary approval has made abortion more convenient for abortion providers and also possibly more convenient for some women seeking abortion by medical means, it has certainly had a detrimental impact on the safety for women.
The decision for any woman to choose abortion over continuing her pregnancy is very often difficult, emotive and complex. Sometimes women are under tremendous emotional or other pressures, often from others, to undergo abortion when they are really not sure if that is what they really want to do. The lack of face to face consultations is entirely insufficient to help women in these difficult situations to discuss in the detail they require the emotional and psychological impact of undergoing abortion, in addition to the potential risks to their physical health associated with the procedure.
There is a particular concern that the temporary measures greatly facilitate abuse of the Abortion Act and allow abortions to be carried out illegally. This includes the very real risk of abortions being carried out on minors with the medications obtained by other persons and also a risk of surreptitious administration of the abortion-inducing medications being administered to pregnant women without their consent.

Q2: 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 might include greater workforce flexibility, efficiency of service delivery, value for money etc. Please provide your reasons.

The temporary measure has proved more convenient for abortion providers and may allow the staff providers to have consultations by telephone calls from a variety of locations. On the other hand, the service provided by telephone consultations, without face to face encounters, in the long-term may have a negative impact on the ability of healthcare providers to provide a high quality service. Healthcare providers need to receive adequate training and supervision. This must always necessarily involve physical examinations and real face to face consultations with service users (in any area of healthcare and medicine). Long term use of telemedicine and telephone consultations, rather than face to face encounters, will very likely result in a significant lowering of standards in service provision and, in the long-term, will represent poor value for money.

There is also a very real possibility that the absence of physical encounters with patients and service users may lead to a lowering of morale among healthcare professionals, as the job satisfaction that arises from actually meeting people and helping them deal with their complex problems will be absent. Service providers will become less empathetic and their work will become more mundane. Both healthcare professionals and healthcare users will suffer from a poorer quality service.

Q3: What risks do you consider are associated with the temporary measure? If you consider that there are risks, can these risks be mitigated?

There are many risks.

First of all, there are the inherent risks associated with the medications Mifepristone and Misoprostol, the drugs most commonly used in inducing medical abortion. These risks include the potential for major haemorrhage; requiring hospitalisation and blood transfusion in many cases. There is an additional serious risk of sepsis, resulting from incomplete abortion and, in some rare cases, this risk includes the risk of death. Two deaths of mothers associated with undergoing medical abortions were allegedly reported in the UK in 2020. More than 24 deaths of women undergoing medical abortion have been confirmed in the USA in recent years. These risks to the physical health and life of the pregnant woman are higher in later pregnancies.

The absence of face to face consultations, with the abortion provider never actually meeting the person requesting abortion, increases the likelihood that abortions will be carried out at later stages than is allowed by the current law and therefore increases the likelihood that these complications will occur in significant numbers, placing patients at considerable risk. There have already been many reports that the law has been broken by provision of abortion pills without any supervision and abortions being carried out at later stages than currently allowed by law.

There are, however, many more serious risks that are directly related to the temporary measure of allowing abortions to be carried out without face to face encounters with the client potentially seeking abortion. The most serious risks are those related to the potential for abuse of the telemedicine system. Without face to face consultations, there is no way that the person providing the abortion pills can ascertain that the person they are in communication with is actually the woman seeking an abortion. This system makes it very easy for others to obtain abortion pills and administer them surreptitiously to a pregnant woman without her consent. Similarly, with this temporary telemedicine system, there is no way for the provider to be certain that a woman seeking the abortion pills through a telephone conversation is not being coerced into doing so against her will. The system allows abuse of minors and victims of sex trafficking to remain undetected simply because it is so easy to obtain the abortion-inducing medications to administer to others.
The absence of face to face consultations also means that some ectopic pregnancies will go undetected until potentially life-threatening complications occur. In standard practice, most pregnant women receive the benefit of undergoing ultrasound examinations to ensure that their pregnancy is viable and within the uterus. This ultrasound scanning service is absent from a service provided by telephone conversations alone.

There is sadly no way for these risks to be mitigated without face to face consultations and proper medical supervision. Even with face to face consultations, the risks associated with women suffering serious haemorrhage, sepsis and the psychological trauma of seeing the aborted foetus in many cases remain, as Mifepristone and Misoprostol are not benign medications. The potential for some of the other risks outlined above can be reduced and warning signs of potential abuse can be more easily identified with face to face consultations.

Q4: In your experience, have other NHS Wales services been affected by the temporary approval? If so, which?

Not to my knowledge.

Q5: 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.

Yes. There are many benefits. The exact stage of gestation and whether or not the pregnancy is actually viable can be determined by physical examination and ultrasound examination. This cannot be done by telephone consultations alone.
Meeting the pregnant woman face to face and having a detailed discussion of her options and what abortion involves will help the provider to recognise if the woman truly wants to undergo this procedure and that she is not being coerced by others to do something against her will. It also ensures that the woman receiving the abortion-inducing medication is actually the woman for whom these drugs are intended and that they are not being obtained for provision to another person, possibly a minor or a victim of abuse.
The current law, including the temporary measure, allows for Mifepristone and Misoprostol to be provided by post following a telephone conversation with a recognised abortion provider but only if the pregnancy has not advanced beyond 10 weeks. Requiring at least one visit to a service, with review by a qualified clinician, helps to ensure that these medications will not be provided at later stages of pregnancy without adequate supervision. To administer them at later stages, without adequate supervision, carries a potential serious risk to the woman who receives them.

Q6: 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?

The impact of allowing medical abortions to take place at home on a permanent basis without face to face consultations is likely to be felt across all community groups. There may be an added risk to some women from some ethnic or religious backgrounds where pregnancy outside of marriage may be stigmatised or considered disgraceful and where pressure may be placed on young women to undergo abortions against their will or consent. As outlined above, it is not difficult for others to obtain the abortion-inducing drugs by post following a telephone conversation and to administer them forcefully or secretly to a pregnant woman without her consent in order to induce abortion.

The potential risk to minors and victims of sexual abuse has been highlighted in the answers above and this risk will be heightened by making the temporary measure permanent. Lessons need to be learned from The Independent Inquiry into Child Sexual Exploitation in Rotherham and other similarly chilling reports. The Rotherham Inquiry report states that many of the victims of sexual abuse became pregnant as a result of the abuse they suffered and many underwent abortions. Opportunities were missed on many occasions to identify these victims of exploitation when they underwent abortion procedures. The absence of face to face consultations makes it much easier for perpetrators of sexual exploitation to continue the abuse of children and others when unintended pregnancies occur and abortions are induced. Members of poorer communities and some minority ethnic backgrounds are much more likely to suffer from this form of abuse and from the lack of adequate medical involvement.

Q7: 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?

Abortion is already very easily accessible in the UK, in all geographical regions. Making the temporary measure permanent will have little impact in terms of its availability for women in economically disadvantaged situations. It might make it more convenient for some women to undergo abortion without the need to travel for clinic appointments or consultations. Convenience, however, should never override safety in healthcare provision.

Q8: Should the temporary measure enabling home use of both pills for EMA:

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

Q9: We would like to know your views on the effects that the Termination of pregnancy arrangements in Wales would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

No effect comes to mind. It is possible that a Welsh-speaking woman may only have access to an English-speaking abortion provider on a telephone conversation but this could also happen in face to face consultations. On a clinic visit, however, there may be a greater likelihood of finding another person close at hand with Welsh-speaking ability.

Q10: Please also explain how you believe the proposed arrangements could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

No measures that would be likely to be helpful come to mind.

Q11: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

The Catholic Medical Association (UK) [CMA (UK)] has members in both the North Wales and South Wales regions. Since May 2020, the CMA (UK) has provided a service for woman who request "abortion pill rescue" therapy. Those seeking this service are pregnant women who have initially taken the first abortion pill, Mifepristone, but who, shortly afterwards, change their minds and wish to preserve their pregnancies and save their babies' lives. There is increasing evidence that early provision of high-dose Progesterone therapy can sometimes (in 50-70% of such situations) preserve the pregnancy by counteracting the effects of Mifepristone. When the service was initially introduced last year, in response to the demand from these women in distress, it was estimated that no more than 10-20 requests might be made for this rescue treatment per year. In less than 10 months since the service was started, however, more than 110 requests for rescue treatment have already been made. This represents a 10-15 fold higher than expected demand for this service. It is worth pointing out that this is also a largely unknown service at present. It is very likely that the temporary measure of allowing early medical abortions to be carried out without proper consultations has resulted in many young women making decisions to abort in a panic that they very quickly regret. We know this because many of the young women who seek our help have informed us that they felt under pressure to proceed with abortion during and after the telephone consultations they experienced with the abortion providers. Many felt that they were not given the time to adequately make an informed decision with sufficient counselling before taking the Mifepristone tablet. This problem will be aggravated by making the temporary measure permanent.

Submit your response

You are about to submit your response. Please ensure you are satisfied with the answers you have provided before sending.

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