At-home abortions: the case against a permanent policy

This document contains important information on the poor evidence base for making at-home abortion permanent. Abortion policy should not be based on evidence that ignores the risks of at-home abortion for the health and wellbeing of women.

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Introduction

At-home or telemedicine abortion was introduced on 30 March 2020, as a temporary measure during the pandemic.

The Department for Health and Social Care in Westminster, the Scottish Government and the Welsh Government are now considering whether at-home abortions should be made permanent.

Here we set out why at-home abortions should end immediately. The Secretary of State for Health in Westminster, the Minister for Public Health and Sport in Scotland and the Minister for Health and Social Services in Wales need to understand fully this vital information. Ministers should honour the undertaking that at-home abortion would be a temporary measure only.

In this briefing we look at:

- Wrong assumptions made about at-home abortion.
- Misleading or negligent guidance from the Royal College of Obstetricians and Gynaecologists (RCOG).
- Flawed or selective evidence used to support at-home abortion.

Wrong assumptions about at-home abortion

ASSUMPTION 1: At-home abortion is safe and simple, just like any other medical procedure.

WRONG: A Finnish study found 15.6% of women who took abortion pills went to hospital for bleeding described by the authors as a haemorrhage, approximately one fifth of whom required treatment.[1] And these were women who took the pills under medical supervision. At-home abortion means the woman is on her own dealing with pain and bleeding and having to make her own assessment of whether she needs medical help or not.

ASSUMPTION 2: The public is in favour of at-home abortion.

WRONG:

- Seven in ten adults in England (71%) say they are concerned about women having a medical abortion at home after a phone or video consultation with a doctor. One in five (22%) say they are not concerned.
- More than eight in ten adults in England (84%) say they are concerned about women finding it distressing potentially having to dispose of the terminated pregnancy either into the toilet or sanitary pads. 11% say they are not concerned.[2]

ASSUMPTION 3: At-home abortion makes access to abortion easier, reduces waiting times and does not lead to more abortions.

WRONG: Following the onset of at-home abortion, the DHSC reported: "For every month between January to April of 2020, there were more abortions performed compared with the corresponding month of 2019. In April 2020 there were just over 4,500 more abortions compared with April 2019."[3]

Claims that waiting times are reduced between first contact with the abortion provider and the abortion taking place, cannot be substantiated. A 2020 study [4] calculated waiting times for telemedicine from first access to posting drugs which were then taken an unknown time later, compared with drug taking at a clinic which could be observed and was therefore more accurate. The study did not take account of delays in the postal service during the pandemic.

ASSUMPTION 4: At-home abortion is properly regulated.

WRONG: It is virtually impossible for abortion providers to know the true circumstances of the women they are speaking to on the phone. A mystery client investigation[5] reported on 26 women who each made two or three phone calls, taking no more than an hour, to one of three British abortion providers.

Each woman, none of whom was pregnant:

- gave a false name,
- gave a fictional medical history and gestational age and
- was not registered at the GP surgery she gave to the abortion provider.

All 26 were sent abortion pills through the post. At-home abortion is wide open to abuse.

[1] Niinimaki M *et al.* (2009) Immediate Complications After Medical Compared with Surgical Termination of Pregnancy. Obstet Gynecol 114:795–804

[2] Savanta ComRes poll December 2020 https://comresglobal.com/polls/spuc-england-polling/

[3] www.gov.uk/government/publications/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic

[4] Aiken A *et al.* (2020) Effectiveness, safety and acceptability of no-test medical abortion provided via telemedicine: a national cohort study. https://doi.org/10.1111/1471-0528.16668

[5] www.christianconcern.com/wp-content/uploads/2018/10/CC-Resource-Abortion-At-Home-A-Mystery-Client-Investigation-201210.pdf

ASSUMPTION 5: **It is "completely unnecessary for women to attend a clinic to take a pill".**[6]

WRONG: A clinic consultation before an abortion has never been just about taking the pills. When a woman attends a clinic:

- The gestation of the pregnancy can be established by an ultrasound scan (a crucial consideration when the pills can only be used up to a certain gestation).
- The time of drug ingestion is known accurately in relation to gestational age.
- She can be assessed to determine if a medical abortion is suitable for her.
- Consent can be gained.
- She is seen alone, which could, in theory, help to ensure that she is not being coerced.

ASSUMPTION 6: **There are *fewer* complications from home abortions than in clinic.**

WRONG: Data published by the Department of Health and Social Care must be challenged. The DHCS states that in the months April to June 2020, there were 23,061 telemedicine-enabled abortions at home in which women self-administered both mifepristone and misoprostol. It reports just one complication.[7] This represents a case rate for complications of 0.043 per 1,000 abortions. A former consultant to Marie Stopes International commented: "So, if the complications rate for early medical abortions has been 0.74 per 1,000 abortions for many years, why would it now drop by a factor of 17 times, to just 0.043 per 1,000?" [8] [9]

[6] www.politics.co.uk/comment/2021/01/14/new-abortion-rules-must-remain-after-the-pandemic/

[7] www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020 "Abortion statistics during COVD-19: supplementary analysis, freedom of information requests and other data releases"

[8] www.percuity.blog/2021/01/02/is-the-rate-of-abortion-complications-falling

[9] Instead, the data suggests that doctors are completing and submitting the HSA4 form (which usually records complications) at the same time as the abortion pills are being posted to the woman. This means complications are not being recorded on the forms. It is also clear from the results of a mystery client survey [check this ref within a ref and the numbering] that both BPAS and Marie Stopes UK are directing their clients to self-assess for any signs of complications and if necessary, to report to their local hospital. Any complications are therefore being dealt with by hospitals, and would not show up on the DHSC statistics.

In response to a freedom of information request, six hospitals reported 69 women treated for complications after a medical abortion, in the first 11 months of 2020. This is a complications rate more than five times higher than that reported by DHSC. The DHSC needs to take into account all the data, not just what is recorded on abortion notification forms. https://percuity.files.wordpress.com/2021/02/complications-from-ema-kd210211.pdf

Guidelines from the Royal College of Obstetricians and Gynaecologists (RCOG)

In 2020 the RCOG issued guidelines: *Coronavirus (COVID-19) infection and abortion care – Information for healthcare professionals*

Bias in the RCOG guidance.

It might be expected that the RCOG would draw up guidelines based on independent research, enabling them to make a professional and accurate judgement of the risks to women of at-home abortion. This was not the case.

Two of the five authors of the guidance are from organisations which provide abortion and have a strong motivation to promote at-home abortion:

- Dr Jonathan Lord, Medical Director, Marie Stopes UK
- Dr Patricia Lohr, Medical Director, British Pregnancy Advisory Service

Among the studies cited in the guidance, a number are authored by people affiliated to or employed by organisations with a strong vested interest in abortion. These include leading US abortion provider Planned Parenthood and also Gynuity Health Projects which "has been at the forefront of efforts to increase women's access to medical abortion in settings throughout the world".[10]

It is noteworthy that the loose interpretation of the 1967 Abortion Act prior to the pandemic meant that the RCOG could count on there being few legal or practical obstacles to implementing a "pills through the post" regime.

Key points of concern in the RCOG guidance:

The requirement for two doctors to sign-off a remote abortion. The RCOG states that this can be met if a "registered medical practitioner relies on the information obtained by other members of their team when certifying an abortion. This certification can be performed remotely, including through use of their electronic signature applied to the HSA1 form."[11]

- Blanket use of electronic signatures is a long way from a doctor making a clinical judgement about whether a woman is eligible for an abortion, as is required by the 1967 Abortion Act. In fact, in remote abortion it is the woman herself who is providing the information on her medical history and gestational age. The doctor only has the notes made by the nurse after her call with the woman. The doctor is effectively signing off "in good faith" only what the woman herself has said.

No requirement for an ultrasound scan. The RCOG points out that "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".[12] This means that 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'".[13]

- Women taking abortion pills after the 10-week gestational limit is a significant risk under the remote abortion scheme. This risk is reduced if the woman is seen in person, because a scan can be done if there is doubt about the gestational age. The RCOG acknowledges that: "Mortality and morbidity with abortion… increases exponentially for each additional week of pregnancy after 8 weeks' gestation".[14] Yet, keeping doctors and women on the right side of the law seems to be a more important consideration.

"Advantages" to vulnerable women. The RCOG states that: "Remote consultation may enable vulnerable women, for example those with a coercive partner, to access care more discreetly, especially during COVID-19 and lockdown."[15]

[10] https://gynuity.org/programs/medical-abortion accessed 9/2/2021

[11] https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-covid-19-infection-and-abortion-care.pdf

[12] *Ibid* page 13

[13] *Ibid* page 13

[14] *Ibid* page 8

[15] *Ibid* page 24

- Vulnerable women are made even more vulnerable under the remote abortion scheme as they do not have the opportunity to see a health worker in private, away from an abuser. Studies show the prevalence of abortion among abused women.[16] [17]
- Far from enabling vulnerable women to access an abortion more discretely, remote abortion, particularly during the pandemic, can leave women unable to get the help they need. A 39-year-old woman with three children from a previous relationship and with a "very controlling" partner who had received abortion pills through the post told a newspaper in May 2020: "I'm still bleeding even now, a few weeks on. Because my partner is here and doesn't know what I did, I've not been able to ring anyone for any advice." [18]

Managing pain. The RCOG states: "Occasionally and not always predictably, women may find the pain from medical abortion to be particularly distressing. Therefore, providers should offer a stronger analgesic such as codeine or co-codamol 30/500 as back-up analgesia."

- This is misleading. One study showed that 62% of women taking Mifepristone (RU486) and Misoprostol and 48% of those taking Misoprostol alone experienced pain they described as severe.[19] At-home abortion is a traumatic and frightening experience for many women.[20] Downplaying the pain experienced in the procedure is giving women a false impression of what is involved in aborting her baby at home. Codeine phosphate tablets are included in the treatment packs posted to women by abortion providers. Codeine phosphate is a Class B controlled drug liable to abuse and so it is rarely prescribed alone and prescribing it for pain relief is inappropriate and unsafe, and inconsistent with NICE guidance.[21]

Determining gestational age of the pregnancy. The RCOG states that: "Most women can determine the gestational age of their pregnancy with reasonable accuracy by LMP (last menstrual period) alone".

- Many pregnant women do not know their gestation until they have a dating scan. When women guess, they tend to underestimate their gestation. Usually the last menstrual period (LMP) is used to estimate gestational age, but LMP alone is not the best obstetric estimate because it assumes a "regular" menstrual cycle.[22] Studies report that women do not accurately recall their LMP.
- A South African study found an average of 19 days' underestimation of gestational age by women when compared with ultrasound. This paper also suggested that woman may have an incentive to underestimate so as to come within the legal limit.[23] The consequences for women misjudging their pregnancy dates could be severe. In one UK study more than 50 per cent of women having abortions after 13 weeks (so only a few weeks difference) needed subsequent surgical intervention.[24]

Supplying extra drugs. The RCOG advises giving women extra misoprostol in remote abortion packs in case the abortion is not completed after the first dose: "Given that it is especially important to reduce contact during the COVID-19 pandemic, providing a second dose of misoprostol for women to use 3–4 hours after the first dose if they have completed the abortion would seem prudent. If units do not have supplies of one additional dose of 400 micrograms and are unable to pack down their stocks of 800 micrograms, they should give two sets of 800 micrograms and advise the women to use this for a second dose if required".

[16] Silverman JG, Decker MR, McCauley HR, Gupta J, Miller E, Raj A & Goldberg AB (2010) Male perpetration of intimate partner violence and involvement in abortions and abortion-related conflict. *American Journal of Public Health* 100 (8):1415-1417.

[17] Kirkman M, Rosenthal D, Mallett S, Rowe H & Hardiman A (2010) Reasons women give for contemplating or undergoing abortion: A qualitative investigation in Victoria, Australia. *Sexual and Reproductive Healthcare* 1:149-155.

[18] Daily Mail, 29 May 2020

[19] Dahiya K et al. (2012) Efficacy and safety of mifepristone and buccal misoprostol versus buccal misoprostol alone for medical abortion. Arch Gynecol Obstet 285:1055–1058.

[20] Katherine A. Rafferty & Tessa Longbons (2020): #AbortionChangesYou: A Case Study to Understand the Communicative Tensions in Women's Medication Abortion Narratives, Health Communication, DOI: 10.1080/10410236.2020.1770507

[21] https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html and https://bnf.nice.org.uk/drug/codeine-phosphate.html

[22] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date

[23] Blanchard K, Cooper D, Dickson K, Cullingworth L, Mavimbela N, von Mollendorf C, van Bogaert L, Winikoff B. A comparison of women's, providers' and ultrasound assessments of pregnancy duration among termination of pregnancy clients in South Africa. BJOG 2007;114:569–575.

[24] Oral mifepristone 600 mg and vaginal gemeprost for mid-trimester induction of abortion. An open multicenter study. UK Multicenter Study Group. Contraception 1997;56:361–6.

- This is an admission that the abortion drug regimen is not precise and that taking abortion drugs is not simple and straightforward. The burden of assessing the progress of the abortion is placed on the woman. These are powerful drugs which are being sent to a domestic setting where a woman is expected to undergo the pain and distress of performing her own abortion and at the same time monitor her progress and make judgements about whether the abortion is complete and/or judge the severity of her pain and bleeding.

Often quoted studies which favour at-home abortion

A number of studies are often quoted in support of at-home abortion by those wishing to make this permanent. There are two key problems with these studies:

1. The authors of the research have a conflict of interest regarding at-home abortion.
2. Adverse effects of at-home abortion reported in the studies are often ignored.

Here are some examples:

Purcell, C., Cameron, S., Lawton, J., Glasier, A. and Harden, J. (2017) Self-management of first trimester medical termination of pregnancy: a qualitative study of women's experiences. ***BJOG: An International Journal of Obstetrics and Gynaecology,*** **124**

Often quoted: The authors of this study concluded that most women preferred home management of abortion. The bad experience of a woman bleeding on the bus after taking the second dose of abortion pills at the clinic, is often quoted in support of at-home abortions.

Often ignored: However, the same study includes quotations from women who had taken both abortion pills at the clinic and went home to pass the pregnancy:

- "such a physical and emotional process",
- "day was absolutely horrific",
- "I bled so much … it's pouring out",
- "in hindsight I wished I hadn't looked but I did, and that was probably the most traumatic thing I've ever seen or done",
- "if [my friend had] been there and seen me screaming like that…".

Platais I, Tsereteli T, Grebennikova G, Lotarevich T, Winikoff B. Prospective study of home use of mifepristone and misoprostol for medical abortion up to 10 weeks of pregnancy in Kazakhstan. Int J Gynaecol Obstet. 2016 Sep;134(3):268-71. doi: 10.1016/j.ijgo.2016.02.018. Epub 2016 May 26. PMID: 27352735.

Often quoted: This study by Gynuity Health Projects, concludes that "outpatient medical abortion with mifepristone and misoprostol is safe and effective up to 70 days of pregnancy".

Often ignored: This study is out of step with just about every other study on telemedicine abortion; it showed a 99% abortion completion rate, which is almost unheard of, and no adverse events, which is also completely unheard of.

By contrast, a study by Endler *et al.* (2019) of a Women on Web telemedicine abortion trial found that surgery was needed for 12.5% of women with gestational age of less than 9 weeks, and 22.6% for women over 9 weeks.[25]

Raymond EG *et al.* (2019) TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States. *Contraception* 100:173–177.

[25] Endler M *et al.* (2019) Safety and acceptability of medical abortion through telemedicine after 9 weeks of gestation: a population-based cohort study. *BJOG* 126:609–618.

Often quoted: This is the first US study of telemedicine abortion where the woman had no face to face contact with a medical professional at all. The study concluded that "this direct-to-patient telemedicine abortion service was safe, effective, efficient, and satisfactory".

Often ignored: The key authors, including the corresponding author, are Gynuity employees. A key point in this study is that the women had an ultrasound to assess the gestational age of the pregnancy, prior to the remote consultation with the abortion provider. Where no ultrasound scan has taken place, as in the current at-home scheme in Britain, the gestational age of the pregnancy can be in doubt.

- 6% had surgical interventions
- 2% had serious adverse events (a seizure and a blood transfusion).

Aiken AR et al. (2017) Self-reported outcomes and adverse events after medical abortion through online telemedicine: population based study in the Republic of Ireland and Northern Ireland. *BMJ* 357:j 2011.

Often quoted: This study, co-authored by Women on Web director Rebecca Gomperts, concludes that "Self-sourced medical abortion using online telemedicine can be highly effective, and outcomes compare favourably with in clinic protocols."

Often ignored: The percentage of women they got outcome data for was less than 71% of the total who were sent abortion pills. Even of these, 4.5% of women reported needing surgical intervention for an incomplete pregnancy. 2.6% reported taking antibiotics either orally or intravenously, and 0.7% reported having had a blood transfusion. 9.3% reported "experiencing symptoms of a potentially serious complication".

Gomperts R *et al.* (2014) Provision of medical abortion using telemedicine in Brazil. *Contraception* 89:129-133.

Often quoted: This study by Women on Web director Rebecca Gomperts concludes: "Home use of mifepristone and misoprostol provided through telemedicine is safe and effective".

Often ignored: This study reports:

- The overall rate of completed abortions was 76.9% and:
  - 20.9% required surgical intervention
  - 10.9% had continuing pain
  - 12.5% had heavy bleeding
  - 3.1% had fever or discharge

Hyland P et al. (2018) A direct-to-patient telemedicine abortion service in Australia: Retrospective analysis of the first 18 months. Aust N Z J *Obstet Gynaecol* 2018; 58: 335–340.

Often quoted: The report was led by the medical director of the facility that ran the service, and by Gynuity researchers. This study is an example of an abortion service provider researching the performance of their own fee paying service and concluding that, by and large, all is well. The medical director has a direct financial conflict of interest.

Often ignored: This study received follow up data from 754 women (78% of the total), of whom 96% were reported to have had a complete abortion.

- Of these women, there were 37 (4.9%) who were hospitalised or had an outpatient visit.
- Of a further 211 women who they had little information about, 14 (6.6%) were hospitalised or had an outpatient visit.

Because the complication rate was higher amongst those about whom they had minimal data, and could have been considerably higher still, it is likely that the overall complication rate is higher than it might at first appear.

Grossman D & Grindlay K (2017) Safety of medical abortion provided through telemedicine compared with in person. *Obstet Gynecol* 130:778–82.

Often quoted:

This study found that the clinically significant adverse events rate was 0.32% for in-person patients and 0.18% for telemedicine patients, leading the authors to conclude that medical abortion via telemedicine was superior to an in-person visit.

Often ignored:

- The lead author, Daniel Grossman, is a director of ANSIRH (Advancing New Standards in Reproductive Health).
- Few others are as deeply involved in advocacy for demedicalised abortion as Grossman, as well as being well networked with major funders, including Danco Laboratories, which markets Mifepristone in the US.
- This is essentially a Planned Parenthood (PP) study that relies almost exclusively upon reports made by PP clinics to PP America, who in turn report to Danco Laboratories, the distributor of Mifepristone in the US.
- This means that PP clinics can decide what they send to PP America, who in turn can decide what they send to Danco – who have a clear conflict of interest as gatekeepers of the data. Danco makes millions out of Mifepristone, and the more adverse events there are, the more they stand to lose. The Grossman study claims Danco then sends the reports to the FDA.
- In 2006 Gary and Harrison undertook a study of the FDA's adverse events reporting system in relation to Mifepristone and concluded that it was seriously deficient.[26]
- Grossman's study is at odds with other research. It is important to note that the rate of adverse events it reports do not include those complications most often reported in other studies. Even for those events they do report, the rate is low.

[26] Gary MM & Harrison DJ (2006) Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient. *Annals of Pharmacotherapy* 40(2):191-197.

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

This 2020 study deserves particular scrutiny as it claims to present: "Compelling evidence from 52,145 women shows telemedicine abortion is safe, effective and improves care". This has been widely cited in favour of making at-home abortion permanent. There are significant shortcomings in this study which must be recognised.

The study group

The study is designed to compare a telemedicine delivery service model with a traditional service model.

The study group comprised 22,158 women seeking early medical abortion (EMA) under the traditional model (i.e before the government changes), and 29984 under the telemedicine-hybrid model (T-H, after those changes).

The T-H model was actually split between 18435 (61%) who were provided EMA *entirely via telemedicine* (phone consultation with gestational age determined by reported last menstrual period, and with drugs posted or picked up), and 11549 (39%) who had an in person visit with ultrasound.

The flaws: The breakdown of the T-H cohort is confusing and not explained. Why compare the traditional model with a mixed group of some telemedicine and some in person? The in person group within the T-H cohort is really similar to the traditional group. One is left surmising that the mixing would likely dilute any differences between telemedicine and traditional service delivery models.

Success rates

The study says that "rates of successful medical abortion are high under both service delivery models – 98.2% in the traditional cohort and 98.8% in the telemedicine-hybrid cohort".

The flaws: The authors show data for each and every woman, and therefore make claims about 98%+ success rates. But the paper does not make clear how they know this. Did the abortion providers follow up every woman to seek self-reported outcomes? By phone, in person, online? They do not say. Indeed, the authors do not even say how completion was measured – via pregnancy test, ultrasound? How do they know what the outcomes were for *every single woman* – something pretty much unheard of even in dedicated trials let alone via telemedicine for a whole of population group?

This issue is important because it relates to one of the key claims of the paper, and yet it is nothing short of staggering that they have such data from everyone when even clinical trials can't get close.

The authors admit that: "The main limitation of this study is that we were unable to actively follow up patients post-abortion and therefore only significant adverse events can be reported with confidence."

This is a clear admission that they did not follow up patients post-abortion. So how can they report so definitively about completion rates?

Adverse events

The authors set the bar for complications very high at blood transfusions, IV antibiotics in hospital, major surgery and death. There are other complications that can be serious and important indicators of harm. Moreover, patients could present as a complication of miscarriage, not early medical abortion.

The flaws: There is no explanation in the study of how adverse events were assessed. The authors start out by saying, 'There is a potential gap in the consistency of reporting incidents, due to some complications not meeting the threshold of serious incidents, multiple routes of entry into the NHS and informal communication between the NHS and abortion providers.' This sounds like a fair statement about the problems with picking up adverse events from a study in which patients were de-identified, so no cross checking could be undertaken with hospitals or other health records (a huge task in any case). Despite identifying a gap, the authors then say, "the risk management and reporting systems within the NHS are well defined, with serious incidents being routinely shared", and that abortion providers are in touch with the Care Quality Commission, which in turn makes known adverse events to providers.

Without any means of properly checking health records for individual women, assessment of adverse events is certainly underestimated, potentially by a large amount.

Gestational age

The study claims that telemedicine means that abortions are happening earlier in the pregnancy.

The problem: The GA (gestational age) in the telemedicine group will be underestimated because of the way GA was determined. It was based on the woman's recall of last menstrual period up till the date of *posting* drugs. The date of actual drug taking was unknown and hence GA at the time of drug use could be many days later (taking into account postal time during the pandemic plus any delay for personal reasons such as ambivalence). Moreover, despite what the authors claim, GA via last menstrual period is known to be underestimated.

The claim that telemedicine led to medical abortion at an earlier GA is therefore unsustainable.

Conflict of interest

Three of the five authors of this study are directly connected with abortion providers in Britain:

- Dr Patrica Lohr, Medical Director, BPAS
- Dr Jonathon Lord, Medical Director, MS UK Reproductive Choices
- Dr Nabanita Ghosh, Medical Director, NUPAS

The authors have an obvious conflict of interest as directors of abortion provider organisations. That conflict is both in terms of image (providers must be seen to provide a safe and effective service), as well as financial.

Conclusion

This study lacks so much important information that it is difficult to be sure how reliable are any of the findings, and therefore the conclusions are unreliable. The claim that "Compelling evidence from 52,145 women shows telemedicine abortion is safe, effective and improves care", is unsupportable.

This study should not be used to support at-home abortion becoming a permanent measure in Britain.

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