

Abortion  
at Home:  
a Mystery  
Client  
Investigation

During the coronavirus lockdown, the biggest change to abortion procedure since the Abortion Act 1967 took place, with abortions being authorised with no in-person consultation.

The policy raised concerns that the system could be misused, whether by women or by coercive family members and partners, and lead to unsafe abortions. To test whether our fears were founded, we commissioned public health expert Kevin Duffy, a former Marie Stopes International director, to conduct a mystery client exercise.

His findings are published in this report, which I commend to you.

[Andrea Williams](#)

*Chief Executive, Christian Concern*

# Contents

4	Executive Summary
4	<i>Key Recommendations</i>
5	Background and Summary
7	Mystery Client Investigation: Methodology
9	Self-Managed Abortion
9	<i>Self Referral</i>
10	<i>Self Assessment</i>
12	<i>Self Administration</i>
13	Grounds
15	Telemedicine Technology
17	Codeine Phosphate
18	Appendix 1: An Introduction to Mystery Shopper Surveys
19	Appendix 2: The Ethics of Mystery Shopping
20	References
21	Transcripts of Mystery Client Calls
21	<i>Eve: Summary</i>
21	<i>Eve's First Call with MSUK</i>
25	<i>Eve's Second Call with MSUK</i>
30	<i>Eve's Third Call with MSUK</i>
37	<i>Saskia: Summary</i>
37	<i>Saskia's First Call with BPAS</i>
42	<i>Saskia's Second Call with BPAS</i>

# Executive Summary

A mystery client survey was carried out to assess concerns about the safety and practice of telemedicine abortions at home.

Key findings of the survey were:

All 26 mystery clients were able to obtain abortion pills using false information for a client who does not exist on the NHS register.

Valid NHS numbers for the clients were not obtained by the abortion providers for any of the clients. NHS are therefore vulnerable to paying for abortion pills to be sent to patients who do not exist on the NHS register.

Telemedicine abortions are entirely reliant on client information about gestational age. In some cases, the clients altered the date of her last period between calls and this was accepted without question.

It is therefore very easy for women to deliberately or mistakenly misdirect the abortion provider into prescribing the abortion treatment in cases when it is neither legal nor safe.

It is also clearly possible that the woman presenting on a call to a provider is not the same as the one treated with the posted pills.

Abortion providers are operating as if abortion on-demand for any reason is legal. Clients gave a number of legally invalid reasons for wanting an abortion and these were accepted without question by the abortion providers.

Calls by mystery clients were all voice-only on mobile phones. On no call did the service provider suggest the use of video-calling which would enable a better assessment of the client.

Treatment packs sent to clients include codeine phosphate, a Class B controlled drug liable to abuse. Prescribing this drug for pain relief is inappropriate and unsafe, and inconsistent with NICE guidance.

## Key Recommendations:

The various risks associated with telemedicine abortions would be mitigated by mandating an in-clinic assessment before the treatment is given to the woman for subsequent self-administration at home.

The telemedicine process should require service providers to collect and validate each client's NHS number before proceeding with the consultation.

Service providers should be required to adopt video calls as the default media for conducting remote consultations.

Service providers should reconsider prescribing and providing codeine phosphate. The dosage should be reduced and self-administration instructions clarified.

# Background and Summary

On March 30th, 2020, the Secretary of State for Health and Social Care approved a pregnant woman's home as a class of place where the treatment for termination of pregnancy (ToP) may be carried out.<sup>1</sup> This approval enabled the implementation of a fully remote telemedicine service in which a woman no longer needs to make a clinic visit as part of the ToP process. Prior to this approval, it was necessary for a woman's eligibility for early medical abortion (EMA) at-home to be assessed professionally by an authorised service provider (SP) during a clinic visit; this assessment routinely included the use of an ultrasound scan (USS) to confirm the gestational age (GA) of the pregnancy.

The approval of a woman's home and the associated implementation of a fully remote telemedicine process mean that the assessment of GA is now solely dependent upon the woman's accurate and honest recall of the first day of her last menstrual period (LMP). The prior use of an ultrasound scan was to overcome any lack of a service provider's confidence in the woman's recall.

Being certain of the gestational age is important because the new regulation limits early medical abortion at home to a maximum GA of 9 weeks and 6 days by the day on which the mifepristone is self-administered. Also, it is accepted that the efficacy of the medical abortion treatment reduces as GA increases, with a resulting increase in the potential side-effects experienced or adverse events arising.<sup>2</sup>

In effect, the woman has been co-opted as an essential member of the multidisciplinary team (MDT) working for the registered medical practitioner (RMP), providing important clinical information necessary for the correct certification of the ToP by the RMP, to ensure compliance with the 1967 Abortion Act. When acting in good faith, the RMP is now solely relying on the woman's accurate and honest disclosure and self assessment.

We designed and implemented this mystery client survey to explore the reality of these concerns; to test the hypothesis that these new telemedicine regulations mean that service providers are now solely reliant on their clients' accurate and honest recall of the first day of their last period and self-assessment of their medical history.

During June and July 2020, our team of volunteers made calls to three independent sector abortion organisations, British Pregnancy Advisory Service (BPAS), Marie Stopes UK (MSUK), and National Unplanned Pregnancy Advisory Service (NUPAS). 26 sets of calls were completed for a variety of personas, client roles being acted by our volunteers. We received 26 treatment packs (pills-by-post) for women who do not exist and are thus not registered by the NHS, and based on a set of false personal and medical data: BPAS 13, MSUK 11, and NUPAS 2.

The report below discusses our findings, which are based upon a detailed review and analysis of each of these calls.

Findings are grouped together as follows:

Discussion of the move from comprehensive professional abortion care to self-managed abortion in which the woman manages her own self-referral, self-assessment, and self-administration.

Legal certification by the Registered Medical Practitioner of the termination of pregnancy under an approved ground.

The move to a fully remote telemedicine process.

Safety concerns related to the provision of codeine phosphate.

The appendix includes an overview of the mystery shopper methodology and related ethics, and full transcripts for each of the calls made by two mystery clients, **Eve** and **Saskia**.

Key recommendations arising are:

- a. To correctly identify the client and to ensure correct use of NHS funding, the telemedicine process should be amended to collect and validate each client's NHS number before proceeding with the consultation. It should be mandatory for inclusion of the NHS number on the HSA4 form and payments should be withheld if this is not completed correctly.
- b. The move to solely relying on telemedicine for the complete termination of pregnancy process means that it is not possible to prevent the regulatory and safety issues presented by self-assessment. These issues can only be avoided by mandating the return to the prior routine inclusion of a clinic-based assessment by an authorised service provider, as part of the overall process, which might then include the self-administration of the treatment by the woman at home.

- c. Service Providers should be asked to adopt video calls as the default media for conducting these remote consultations. This would help to improve the quality of the care provided, compared to voice-only, and would be more consistent with the official guidance and best practice.
- d. Service providers, particularly BPAS, should be asked to reconsider the prescribing and provision of codeine phosphate. The dosage provided should be reduced and the self-administration instructions clarified.

# Mystery Client Investigation: Methodology

The survey assessed the telemedicine services offered by three independent sector abortion organisations, British Pregnancy Advisory Service, Marie Stopes UK, and National Unplanned Pregnancy Advisory Service, to determine how the change in approval of place was affecting the legal compliance, and safety and quality of abortion care.

We recruited a small number of non-pregnant women aged 18-40 as unpaid volunteers for this survey. Each volunteer was asked to take on a specific persona, the role which would be acted during the calls to a service provider. Each volunteer completed a checklist with all the specific data and answers which she would use during each of her calls.

All calls were recorded, and the recordings have been transcribed; we have included full transcripts for two mystery clients, **Eve** and **Saskia**, at the end of this report. We also have video evidence of the volunteers making each of their calls.

For most of the calls, we used one of three personas, as follows:

- a. A woman who is already beyond the ten-week GA limit for early medical abortion and so she provides a false LMP to the service provider to present as being about seven weeks pregnant.
- b. A mother of a fifteen-year-old daughter who is pregnant. The mother does not want her daughter to go through the system and so she makes a call to the service provider, pretends to be seven weeks pregnant and asks for the abortion pills at-home. When received, she administers these to her daughter.
- c. A woman who first gives a date for her LMP which would indicate nine weeks GA, and then she changes this date on her next call to present as just seven weeks, thus remaining within the GA limit for the abortion pills at home.

It should be noted that apart from providing a false statement about being pregnant and thus about the date of their last period, each of the mystery clients provided a false name, date of birth, and contact details. They also provided false registration data when asked for details of their GP surgery. The only real data given was the address to which the abortion pills should be posted, so that the project could ensure the safe receipt, handling, and disposal of the treatment packs.

A total of 85 telephone calls were made; each of these calls followed the providers' own scripted process, with the mystery clients simply providing answers to whatever questions were asked. The BPAS and NUPAS telemedicine process usually involves two phone calls and the MSUK process is three calls. Some extra calls were necessary e.g. if the initial **SP** called did not have an NHS contract for the mystery client's GP surgery or to participate in the **SP**'s market research calls post-procedure.

Calls were made from various locations using addresses across nine counties: Berkshire, Cambridgeshire, Essex, Hertfordshire, Kent, Lancashire, London, Middlesex, and Sussex.

After making 26 sets of calls, we received 26 treatment packs – for women who do not exist and are thus not registered by the NHS, and based on a set of false personal and medical data: BPAS 13, MSUK 11, and NUPAS 2.

# Self-Managed Abortion

## Self Referral

Women are permitted to self-refer for a termination of pregnancy, which means that they do not need to have any discussion with their GP about their pregnancy nor about their consideration of a ToP. A woman can personally initiate the discussion directly with her ToP service provider of choice. During these discussions, the woman can decide to keep everything confidential from her GP and can instruct the service provider to make no contact with her GP surgery. The service provider will comply with this request for confidentiality and will only break it in the event of a serious risk to the woman's health or her safety.

Most NHS clinical commissioning groups (CCGs) have a contract with at least one of BPAS, MSUK, or NUPAS, and under these contracts the NHS will fully cover the costs of the termination of pregnancy service. Women registered with the NHS can access this service completely free-of-charge.

When a woman calls a service provider and initiates her request for a ToP, the first step in the process is for the service provider's call-handler to collect data about the woman's GP registration and to confirm if there is a current contract with the relevant NHS CCG. Recordings of the calls made by our survey volunteers show how easy it is for a woman to present with fictitious personal identification data and to say that they are registered at a specific GP surgery. The personal data given were created specifically for this mystery client survey; the name of the GP and the surgery address were obtained online from that surgery's webpage.

Sometimes the call handler said that they were unable to find a match for these data on the organisation's internal system, but once they had confirmed that a contract was in place, they agreed to enter the details manually.

On a few calls the volunteer was asked to provide her NHS number, to which she replied that she didn't know this and wasn't too sure how to find it. In each of these cases the call handler asked the woman to make sure she was able to provide her NHS number on the next call, which would be with a nurse. We had no cases in which a volunteer was asked to provide her NHS number on the second or on any subsequent calls. In one case, the project team provided a volunteer with a random, system-generated NHS number. This was a valid NHS number in the correct format and range, but of course was not related to this specific mystery client. This number was accepted by the call handler without any question or issue.

The Registered Medical Practitioner performing the termination is required to complete and submit an HSA4 form to the relevant Chief Medical Officer within fourteen days of the ToP. It is important to note that it is not necessary for the RMP to include a client's NHS number when completing the HSA4 form.

In 26 cases out of 26, our survey volunteers were able to access treatment for abortion at home whilst providing project generated personal data and details of a GP and surgery at which they were not registered. The mystery client is not a real person and cannot therefore have a valid NHS registration.

The survey findings reveal a significant gap in the internal registration verification processes used by each of the independent sector ToP service providers, the result of which is fee-for-service payments being made to the service providers by the NHS for women who do not exist on the NHS registry.

This could be fixed by asking every woman for her NHS number and validating this using a simple database which matches a limited set of personal and surgery data. An example would be matching the woman's name, date of birth, and address with the given NHS number and using the NHS number to validate the surgery registration. It should be mandatory for inclusion of the NHS number on the HSA4 form and payments should be withheld if this is not completed correctly.

## Self Assessment

This mystery client survey demonstrates that when abortion care is being provided remotely, the service provider is solely reliant on the woman's honest and accurate declaration in order to ensure that she meets the required criteria before completing the patient consent, and prescribing and posting the treatment. Before the COVID-19 changes, whilst some of this assessment might have been done on an initial phone call, the assessment would have been completed in a clinic by a service provider. During the taking and verification of medical history, the service provider would have been able to validate the woman's eligibility both clinically and by some basic physical tests or examinations, including the routine use of an ultrasound scan.

Our survey shows that in 26 out of 26 cases the volunteer was easily able to provide answers which validated the criteria. None of our volunteers were pregnant at the time of making these calls, each provided a project-generated date for the first day of their last period, LMP, indicating a gestational age (GA) of seven to eight weeks. One of the personas used in this survey was a woman, **Eve**, who on the first call with the service provider gave a true date for her LMP which indicated a gestational age of just over nine weeks.

Realising that this placed her on the boundary of eligibility for early medical abortion at home, **Eve** changed the date of her LMP on the second call with the **SP** to indicate GA of seven weeks. In four out of four cases, the service provider accepted this critical change and continued with the consenting process. Transcripts of **Eve's** three calls with MSUK can be found towards the end of this report, after the References page.

Volunteers were instructed, by the project, to give certain answers to the medical history questions in order to not raise any red flags which might have resulted in the need to make a clinic visit before receiving the treatment. Recordings of the calls reveal that service providers are often rushing through the scripted questions and at times instruct the woman to only answer 'yes or no', or to only answer if she knows of a specific issue. There are a few calls in which the **SP** talks over the woman in the rush onto the next question.

Since these women were self-referring and had asked for confidentiality, the service provider was not able to confirm any of the given medical history or related information with the woman's GP.

Medical abortion can be a safe procedure for women whose eligibility has been correctly assessed. What this survey shows is that it is possible, and simple, for women to deliberately or mistakenly misdirect the service provider into prescribing the abortion treatment in cases in which the GA is beyond the regulated limit of nine weeks and six days, which might result in more than expected bleeding or pain, or with an increased risk of an incomplete abortion and related infection. A service provider might miss indications of suspected ectopic pregnancy because of the answers given by the woman.

The woman might have one of the many comorbidities which would indicate the need for clinic or hospital based care, and which can all too easily be missed when relying solely on her responses to standard scripted questions on a remote telephone call.

It is worth noting that in the telemedicine process being used by BPAS, MSUK, and NUPAS, the woman is responsible for her own self-assessment of whether the termination is proceeding correctly and as expected, and whether the termination has completed correctly. She is given verbal and written guidance on warning signs to be aware of during the procedure, which includes how she can self-assess if she is bleeding too much and needs to present at her local emergency department. She is provided with a checklist and a pregnancy test kit for use three weeks after taking the abortion pills to self-assess completeness. In none of our 26 cases did the volunteer receive any follow-up care calls from the **SP**. The norm is now for the need for follow-up to be self-assessed by the woman and initiated by her.

The move to solely relying on telemedicine for the complete termination of pregnancy process means that it is not possible to prevent the regulatory and safety issues presented by self-assessment. These issues can only be avoided by mandating the return to the prior routine inclusion of a clinic-based assessment by an authorised service provider, as part of the overall process, which might then include the self-administration of the treatment by the woman at home.

## Self Administration

Most of the announcements and much of the ensuing debate about the Secretary of State's approval of a pregnant woman's home as a class of place where the treatment for termination of pregnancy may be carried out, centred on the administration of the first tablet, mifepristone. It was implied that this was the only effect of this approval and that this was inconsequential given that the woman was already permitted to self-administer the second pill, misoprostol, at home.<sup>3</sup>

However, an approval permitting the self-administration of mifepristone by the woman in her own home must be considered in the wider context of the other significant, consequential, changes which were implemented in order to make this approval operational, namely the replacement of the clinic-based service provider assessment of eligibility, by the woman's own remote self-assessment.

As our mystery client survey has shown, it is simply not possible for the registered medical practitioner to be certain that the woman for whom the abortion treatment is being prescribed is actually pregnant, is within the regulated gestational limit, is medically eligible for such treatment, satisfies the legal grounds permitting a ToP, will correctly administer the treatment, will do so in a timely manner, or will successfully and safely complete the termination procedure; most of which the RMP certifies when completing and submitting the HSA4 form to the Chief Medical Officer in the Department of Health.

Prior to the March 30th approval, it was routine for the mifepristone to be administered in a clinic setting by an authorised service provider. The administration of the treatment followed a professional assessment of eligibility for the treatment and confirmation of the ground permitting this ToP.

Permitting the self-administration of the mifepristone at home after only remote consultations introduces a new risk that the woman presenting on these calls will not be the one treated by the posted pills; this in fact was one of the personas played out in our mystery client survey, a non-pregnant mother posing as a pregnant woman in order to obtain the abortion pills which she would then administer to her pregnant adolescent daughter.

Service providers cannot be certain that each of their clients have correctly understood how the abortion treatment is to be administered and the important timing between taking the mifepristone and the misoprostol. Some of these clients are in an emotionally vulnerable state, having to deal with this traumatic (for them) decision and procedure on their own.

**SPs** and the RMP who certifies a ToP, cannot be sure of when their client will actually start the abortion process; even though women are advised to take the mifepristone as soon as the treatment pack is received, there's no way that any of us can know that this will be so, and yet delay beyond the regulated gestation limit is the critical factor determining the safe and successful completion of the termination process using these medications.

Some of the above mentioned risks are mitigated by mandating an in-clinic assessment before the treatment is given to the woman for subsequent self-administration at home; though this will still not address the risks associated with a delay in the administration of the mifepristone or the mistiming of the misoprostol administration.

# Grounds

In its report "Abortion Statistics, England and Wales: 2019", the DHSC states the following:<sup>4</sup>

*Under the Abortion Act 1967, a pregnancy may be lawfully terminated by a registered medical practitioner in approved premises, if two medical practitioners are of the opinion, formed in good faith, that the abortion is justified under one or more of grounds A to G.*

Ground C is defined as follows:

*Ground C. That the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.*

In 2019, 98% of abortions (202,975) were justified using ground C, and 99.9% of these (202,000) were reported as being performed because of a risk to the woman's mental health.<sup>4</sup>

Each of the mystery clients were asked to give a reason she was seeking a termination of pregnancy. The call recordings reveal that regardless of the reason given, the service provider would either comment on this being an emotional reason or say nothing and move on. In each of the calls, the ToP was provided under Ground C for mental health reasons, though there is only one case in which 'mental health' is mentioned as the reason; in all other cases the reason was a form of 'you seem to be unable to cope emotionally'.

Even when the mystery client said that she did not have any mental health or emotional issues, the service provider explained that it needed to be recorded as qualifying under the 'emotional category'.

Women give many varied reasons for seeking their terminations. The reasons given by our mystery clients could be categorised as: autonomy, it's my choice; economic, I can't afford it; education, I need to finish my studies; career, I've just started a new job; family complete, we already have three children, that's enough; timing, it's just not convenient right now; unplanned, I didn't intend this and I don't want to be pregnant; and relationship, he's just not the right partner for me.

When listening to these calls, it becomes clear that there is no real assessment by the service provider of the reasons given, they are simply following the script, aiming to tick mental health under Ground C as quickly as possible and move on to the next part of the call.

A service provider at BPAS told Saskia, one of our mystery clients, that 'any reason other than the sex of the baby is a valid reason to us, but we need to attach it to a legal reason such as, emotionally it's not the right time for you'. On this call, the woman's reason was that she didn't want to worry about looking pregnant on the beach during her upcoming holiday. Her ToP was justified by the service provider as meeting a legal reason of 'emotionally it's not the right time'. The full transcript of Saskia's two calls with BPAS are included at the end of this report.

For the same mystery client, providing the same reason for her ToP, a service provider at MSUK also suggests that this needs to be recorded as 'emotionally unable to continue with the pregnancy due to not being the right time currently'. This **SP** goes on to explain to the client that under the Abortion Act in GB, Marie Stopes can offer an abortion for emotional, mental, or physical reasons. The **SP** explains that the physical reason would mean that it was unsafe to continue with the pregnancy because of some medical condition and that the mental reason would apply if the woman is sectioned under the Mental Health Act. 'Everything else has to come under the

emotional category'.

The **SP** goes on to say, 'It is indeed legal to request an abortion by choice, it certainly is. But we need to categorise it as per the Abortion Act, so that's the reasoning behind it'.

It should be noted that there is no 'emotional category' under the Abortion Act and that it is not legal to request an abortion by choice in GB.

The ground selected for each ToP needs to be certified by the registered medical practitioner on the HSA4 form, and on the HSAI form. In practice, the HSA4 is completed mostly by the administration or clinical members of the clinic multidisciplinary team, and it is likely that the RMP will not need to tick the relevant box in section 6 to indicate the certified ground(s) for the termination. It is very unlikely that an RMP will be involved at all with any client undergoing an early medical abortion at home. The RMP will not be aware of the details discussed between the **SP** and the client about her reason for the ToP, and relies, in good faith, upon these other team members to correctly complete the details on the certification form before it is authorised and submitted by the RMP. Remote assessment weakens this 'good faith' argument as the RMP is relying on the assessment by members of the MDT, and they are now solely relying on the accuracy and honesty of the woman's own self-assessment. Thus, good faith is no longer depending upon a direct, supervisory relationship between the RMP and the MDT, but on the unsubstantiated information provided by the woman being used to tick the box by the MDT.

It seems that these independent sector abortion service providers are operating as if abortion is legal in GB on-demand by the woman, as a matter of her choice. Legal certification is simply a tick-box exercise for 98% of all abortions performed in GB, rather than it being the proper means of governing legal access to a contested healthcare service.

# Telemedicine Technology

There is no doubt that the inclusion of telemedicine into the overall abortion care process can help to reduce time delays and costs, for both the service provider organisation and its clients. Telemedicine is appropriate for the initial contact between a woman and her chosen **SP**, and for follow-up post-procedure. However, as discussed in other parts of this report, telemedicine alone is not sufficient to ensure a safe and accurate assessment of a woman's eligibility for an early medical abortion at home.

The 2019 NICE guideline 'Abortion Care' is often cited as recommending the use of telemedicine for abortion assessments, but this is far from definitive. Indeed, the recommendation to consider providing abortion assessments by phone is in the context of making it easier and quicker for women to access this service. The implied context in this guideline is that phone calls should be considered as part of the process, rather than becoming the whole of the process<sup>5</sup>

It is worth noting that this same guideline also recommends that abortion can be provided without first needing to use an ultrasound scan to definitively confirm the pregnancy. This has been cited as rationale by RCOG for the no-test protocol in its updated guideline for early medical abortion care management during the COVID-19 pandemic.<sup>6</sup> However the context for this NICE recommendation is that organisations providing a surgical abortion without prior ultrasound scan will need to have staff trained to inspect the products of conception for the presence of chorionic villi and a gestational sac. When providing medical abortion without prior ultrasound scan, the organisation must be able to assess serum human chorionic gonadotrophin (hCG) and have staff trained in interpreting test results. This implies that the NICE no-ultrasound protocol is in the context of an overall abortion procedure which includes some clinic-based processes.

This NICE guideline predates the March 2020 change in which abortion-at-home was approved. It was written prior to there being DHSC approval for the abortion procedure to be completed on a fully remote basis; when considering a fully-remote procedure, it would be unsafe to rely upon recommendations made for an abortion procedure which included some in-clinic processes and some remote by phone. We should not adapt these recommendations from a hybrid-location to a fully-remote basis, without first completing a comprehensive safety review based on primary research.

The RCOG guideline for abortion care during COVID-19, states the following:<sup>6</sup>

*Consultations can take place via video-link or on the telephone, but experience from providers who regularly use telemedicine shows that both women and staff value video-links, with solutions that can be delivered from a mobile phone without the need to download additional software being easiest to implement...*

During this mystery client survey our volunteers made more than 80 telephone calls to the independent abortion service providers. Each of these calls were made from a mobile phone and were voice-only. There were no calls in which the **SP** suggested, or insisted, on the use of video-calling and there were no calls in which the **SP** was visible on screen even if the client was voice-only.

There is value in considering or mandating a change to make the use of video-calls the norm, especially given how easy this is and how it has become normalised in so many of our regular remote interactions with family, friends, work colleagues, and other service providers.

# Codeine Phosphate

BPAS, MSUK, and NUPAS include codeine phosphate tablets in the treatment packs posted to their clients. These are provided for pain management and our mystery clients were told that they could take the codeine as and when needed, in addition to or instead of either ibuprofen or paracetamol; the survey recordings reveal a lack of sufficient or detailed guidance on the dosage and time period between self-administered doses of the pain medication.

On the survey calls, service providers often described the expected pain during the passing of the pregnancy to be like or a little worse than that which the woman might normally experience during a heavy period, dysmenorrhea. NICE guidance for management of dysmenorrhea is to use a nonsteroidal anti-inflammatory drug (NSAID) such as ibuprofen and if this is contraindicated to offer paracetamol.<sup>7</sup>

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.<sup>8</sup>

Women presenting with dysmenorrhea at a pharmacy counter, without a prescription, will typically be advised to use ibuprofen, naproxen, mefenamic acid, or paracetamol. Occasionally a pharmacist might suggest co-codamol but because of its addictive nature this is not the first line and would not be routinely recommended.

Service providers tell us that women calling them are often in a vulnerable emotional state; we should therefore question whether it is safe to send codeine phosphate to these women. BPAS provides 28x15mg (420mg), NUPAS 120mg, and MSUK 60mg; the maximum safe daily dosage is 240mg.<sup>9</sup> Taking all 28 tablets supplied in the BPAS treatment pack at once would be a toxic dose for any of these women and would result in her presenting with bluish lips, drowsiness, chest pain, drowsiness, and a slow heart rate. When taken together with alcohol it would be extremely dangerous. There is a significant risk that one of these vulnerable women might intentionally use these codeine tablets for an overdose.

# Appendix 1: An Introduction to Mystery Shopper Surveys

Mystery Shopping is an evaluation strategy commonly used for independent market research and by organisations to self-assess staff performance. There are many different terms used for this, including: mystery shopper; mystery diner; mystery guest; standardised patient; simulated patient; covert patient; and under-cover care seeker. In this survey we decided to use the term mystery client, since the independent sector abortion providers often refer to the women using their services as 'clients'.

A Mystery Client is acting a role, a persona. She (or he) pretends to be a client and presents herself to a business to assess how well staff are adhering to company policy and guidelines, as well as the laws of the land. Many service organisations engage firms to conduct regular mystery visits and assessments, the results of which are then used to refine and focus ongoing staff training and performance management.<sup>10,11</sup>

The Care Quality Commission (CQC) and NHS Trusts use simulated patients to assess aspects of clinical safety and quality of care at hospitals, clinics, and pharmacies. Trusts will typically ask those attending as actual patients and carers to also participate in the completion of the mystery shopper survey. The latter is done in secret and in confidence, but the shopper is not acting or pretending to be

somebody they are not.<sup>12-14</sup>

A study using mystery medical shoppers on the phone, "Mystery shopping in health service evaluation", evaluated the use of simulated patients in the assessment of aspects of clinical safety in a New Zealand primary care telephone triage service. The study concluded: "Simulated patients can be used to evaluate the limitations of health services and to identify areas that could be addressed to improve patient safety."<sup>15</sup>

In 2019, an organisation used mystery medical shoppers to assess how NHS GP surgeries handled registration requests for persons with no fixed abode or no proof of identification. When asked about the resulting survey report, Jackie Doyle-Price, the Parliamentary Under-Secretary for Health and Social Care, said she welcomed the report and noted the importance of raising critical issues in this way.<sup>16,17</sup>

# Appendix 2: The Ethics of Mystery Shopping

Mystery shopping involves subterfuge and the obtaining of information under false pretences; for some, this can seem to be unethical. To come to a definitive conclusion, one needs to consider the purposes of such practices and to weigh these appropriately. In some cases, we find that organisations will do this to themselves, to discover their own service strengths and weaknesses. In some cases, we find regulators doing it to assess the safety and quality of public services. One could argue that these are both ethically permissible given who the initiator is and how the findings are used.

In a study published by the Oxford University Press in association with the London School of Hygiene and Tropical Medicine, King et al. discuss the ethics of using a mystery client in healthcare settings. They conclude that "the deception of healthcare service providers can be ethically justified where (1) other options cannot answer the research questions; (2) risks to the mystery clients and service providers are minimal; and (3) the knowledge generated is of value to society."<sup>18</sup>

We considered it necessary to use a mystery client survey because it is not possible to directly observe a consultation between a woman and her abortion service provider. Nor can we access the medical records and abstract data and findings from these. Given the sensitivities and stigma surrounding abortion, it is difficult to conduct patient exit interviews, and this in any case would raise some ethical challenges.

We determined that there was no risk of harm to our volunteers who only participated after making their own fully informed choice. The context of this being a remote, phone-based survey of telemedicine, enabled avoidance of any potential harm to our volunteers as there would be no physical examinations and none of the medicines received would be administered. There was no question of harm to the service providers, we had decided that the project would not disclose any personal

identifying data related to any of the service providers and our volunteers would not create a need for a **SP** to extend beyond the remit of their normal call handling processes.

We conducted this survey without first obtaining consent from the service provider or from the provider organisations. This is in contravention of ethical norms in medical research which require the fully informed, freely given consent of all participants. In doing so, we relied on this rationale presented by King et al.:<sup>18</sup>

- a. Services are freely accessible by the public and collecting data has minimal risk to providers. Obtaining consent would increase the risk of detection, thereby reducing the quality of data and harming study aims.
- b. Performing the mystery client survey without first notifying the providers allows care to be observed when the providers believe they are treating a real client and, therefore, the survey results are not influenced by the Hawthorne effect.

We considered that the knowledge generated by this mystery client survey would be of value to any future review of the termination of pregnancy telemedicine process.

# Transcripts of Mystery Client Calls

## Eve: Summary

The gestational age at the time of administering the abortion pills is one of the most critical factors impacting the likelihood of a complete abortion and the incidence of known side-effects. The approval given by the Secretary of State, Department of Health and Social Care, permits abortion at home provided that the gestational age is no more than nine weeks and six days by the day on which the first tablet, Mifepristone, is administered.

On her first call to Marie Stopes UK, **Eve** states 4 May as the first day of her last period, which as noted by the service provider, indicates a gestational age of nine weeks and three days. On this first call the service provider does not raise any issue with this GA, even though it is clear that by the time **Eve** would receive the medication at her home, she would have been beyond the regulatory limit of 9w6d.

**Eve** wanted to make sure that she was able to receive the abortion pills at home, she did not want to attend a clinic. She was aware of the 9w6d limit and so on her second call with MSUK, **Eve** changes her LMP date from May 4th to May 18th, saying that she initially made a mistake and has since checked this on her fertility app. The service provider is content to accept this critical change, confirms that her GA is now just over seven weeks and proceeds with the consultation. After the third call, **Eve** received the treatment pack in the post to her home. By the time of self-administration **Eve** was beyond the 9w6d regulatory limit.

This example shows quite clearly how when using telemedicine, abortion providers are wholly reliant on their clients' accurate and honest self-declaration of their gestational age.

## Eve's First Call with MSUK

*TC16*

*MSUK - Call1*

*[Identifying data redacted ###]*

*[call length 10:11]*

**Eve:** Today is the ### July, 2020. It's ### right now, and I am calling Marie Stopes, first call.

**Speaker 2:** Welcome to Marie Stopes International. So that we can direct your call more efficiently, please choose one of the following options: press one for termination of pregnancy. Press two-

**Speaker 2:** If you or the person accompanying you has a high temperature or a continuous cough, please do not attend any face-to-face appointments with us. Instead, please rebook your appointment, and stay home for seven days. You do not need to call 111 or visit your GP. Press one to make a booking or check funding. Press two to change or cancel a booking. Press three if you have had treatment with Marie Stopes International-

**Speaker 2:** Thank you for calling Marie Stopes International. Your call will be answered by the next available advisor. All information you provide is confidential, and will be processed and stored securely. Your call may be recorded for training and quality purposes, and you can access your information upon request.

**SP:** Good morning, **SP** speaking, how can I help?

**Eve:** Hi, I'm calling about ... I want to get an abortion.

**SP:** Okay, yeah. If I could take your first and second name, then I will book you in for a phone consultation with one of my health advisors.

**Eve:** Thank you.

**SP:** Can I take your first and second name?

**Eve:** It's Eve.

**SP:** ###, Eve, and your surname?

**Eve:** ###.

**SP:** Sorry, ###?

**Eve:** ###.

**SP:** Oh, ###. Okay. Sorry, Eve. And what's your date of birth?

**Eve:** It's the ###.

**SP:** ###. Okay. Are you Miss or Mrs?

**Eve:** Miss.

**SP:** And have you used our services before?

**Eve:** No.

**SP:** Okay. And can I just ask you, is this for a private or NHS inquiry?

**Eve:** NHS?

**SP:** Yeah, okay. How did you hear about us today?

**Eve:** I just looked online.

**SP:** Yeah, the internet. Okay. Can you give me the best telephone number to contact you on?

**Eve:** It is ###.

**SP:** ###, yeah.

**Eve:** ###.

**SP:** ###.

**Eve:** ###.

**SP:** ###.

**Eve:** ###.

**SP:** ###. Okay, so I've got ###.

**Eve:** Yeah.

**SP:** Yeah, and what's the name of the GP surgery you're currently registered with?

**Eve:** It's the Museum Practice?

**SP:** The Museum Practice?

**Eve:** Yes.

**SP:** Is that M-U-S-E-U-M? And what town is that one in?

**Eve:** It's in London. 58, Great Russell Street.

**SP:** Yeah, here we go. Bear with me just one moment, while I just check the [inaudible 00:03:30]. That's in Camden, okay?

**Eve:** Is it okay if you just keep it confidential?

**SP:** Yeah, absolutely. Okay. So it's only between you and us, basically. In a minute, I've got some more questions about the [inaudible 00:03:47] which you have to say whether you agree with or don't agree with. But don't worry, we'll go through those for you. You can refer to [inaudible 00:03:54] Marie Stopes. Do you have your NHS number at all?

**Eve:** I don't.

**SP:** No, don't worry. That's okay. We can carry on without that. Can I take the first day of your last period?

**Eve:** It's the 4th of May.

**SP:** 4th of May, okay. Okay, that makes about nine weeks and three days pregnant. Have you taken a positive pregnancy test?

**Eve:** Yes.

**SP:** Yeah. Would you like to speak to a counsellor for any emotional support?

**Eve:** No, that's okay.

**SP:** Okay. That is available before or after treatment should you need it. Can I take your home postcode?

**Eve:** It is ... Sorry, this isn't my apartment, so I'm just going to quickly check it. I mean, I'm living here as a tenant, so-

**SP:** Yeah.

**Eve:** Okay, here it is.

**SP:** I need the postcode of the area where you're registered with?

**Eve:** As in where I'm living, or where my GP-

**SP:** Yeah, so your home address where you're registered.

**Eve:** Okay. Sorry. It's ###.

**SP:** ###, yeah.

**Eve:** ###.

**SP:** ###.

**Eve:** ###.

**SP:** ###. Okay. That comes up as ###?

**Eve:** Yes.

**SP:** And what number is that?

**Eve:** ###.

**SP:** Okay. Yeah, ###?

**Eve:** Yes.

**SP:** ###. Okay, do you give us permission to send post to this address?

**Eve:** Yes.

**SP:** Okay. And do you give permission to talk to a GP in regards to your medical history?

**Eve:** Does that mean you're going to contact my GP?

**SP:** Yeah, possibly. If we need to. Are you happy for us to do that?

**Eve:** I'd rather it didn't go to my GP.

**SP:** No, that's fine. Now, are you happy for us to contact ... to send any post to your home address?

**Eve:** Yeah, that's fine.

**SP:** Yeah, but you just don't want the GP.

**Eve:** Mm-hmm (affirmative).

**SP:** That's fine, okay. Just to let you know that the NHS share your postcode and date of birth, as they pay for your treatment. Is this okay?

**Eve:** Sorry, can you say that again?

**SP:** Yeah. So your postcode and date of birth may need to be shared with the NHS, as they pay for your treatment. Is this okay?

**Eve:** That's fine.

**SP:** Yeah. Do you have any disabilities or written or verbal communication needs?

**Eve:** No.

**SP:** Okay. If you do become ... That's fine. If we need to contact your GP, we would always ask for your permission to do so, but I will put here that no immediate contact, yeah, with the GP?

**Eve:** Thank you.

**SP:** Okay, that's fine. Yeah. Right, let me find you the next available phone consultation. Just need to ask you about the coronavirus. Do you currently have a temperature, a [inaudible 00:06:48] cough or a loss of taste or smell?

**Eve:** No, I don't have any of that.

**SP:** Okay. If you do [inaudible 00:06:55], let us know, so that we can rearrange [inaudible 00:06:56] appointments for you, but if we need to contact you to [inaudible 00:07:00] will be in contact to arrange an alternative, okay? I have got some appointments for tomorrow.

**Eve:** Okay. What time for tomorrow?

**SP:** I can then do ... I'm just having a look at the calendar. Sorry. Can you do between 3:00 and 4:00 o'clock in the afternoon?

**Eve:** Yeah, that's fine.

**SP:** It's a 20-minute phone call. It comes from a withheld private number. We're going to ask you some questions about your medical history, and any medications that you're taking, your height and your weight. No drink or drugs before the appointment, or we'd have to cancel it, okay? If you miss the call once, we'll call you back once more, all right?

**Eve:** Okay.

**SP:** Just for the Department of Health, and statistics, can you confirm your marital status?

**Eve:** I'm single.

**SP:** Okay. What best describes your ethnic background?

**Eve:** I'm British. White British.

**SP:** Okay, and do you want to give us an alternative number if we need to contact anybody else?

**Eve:** I'd rather not. Can I keep it just this number?

**SP:** Yeah, no, that's absolutely fine. Okay. So I'm going to give you a PIN and a password to keep your details confidential. Your PIN is the year you were born, ###.

**Eve:** Sorry, what was this?

**SP:** And the password ... This is a PIN and a password. The password, you choose from the following: a favourite colour, film, food or sport.

**Eve:** I'll go for colour.

**SP:** Yeah, and what's your favourite colour?

**Eve:** ###?

**SP:** ###, okay. Yeah. So that's ###, and your favourite colour is ###, and they're going to call you tomorrow between the hours of 3:00 o'clock and 4:00 o'clock. Is there anything else we can help you with?

**Eve:** I was looking online about the abortions. You're sending pills?

**SP:** Yeah.

**Eve:** By post?

**SP:** [crosstalk 00:08:56]. Sorry, go on.

**Eve:** So that's the kind of abortion that I'm going for. I don't want to go to a clinic.

**SP:** Okay, so when they phone you, they assess you to see whether or not you're eligible to have those tablets sent out to you in the post. If you are, that's fine. They just arrange it. If you're not, you would have to go down to a clinic to be scanned, and they will give you the tablets at the actual clinic appointment.

**Eve:** Okay.

**SP:** All right?

**Eve:** Okay. Thank you.

**SP:** Do you want me to text or email across confirmation of that appointment?

**Eve:** Yeah, that would be good.

**SP:** Yeah, no problem.

**Eve:** Did you say that you could text it?

**SP:** Yeah. I'll text that across to you now.

**Eve:** Okay, thank you.

**SP:** All right? Okay, we are here from 7:00 AM to 11:00 PM for any appointment or booking queries. Our nurses are here 24 hours a day, should you require any medical advice, and there's more information at [mariestopes.org.uk](http://mariestopes.org.uk) as well.

**Eve:** Okay. Thank you.

**SP:** Okay, take care, **Eve:** Bye-bye.

**Eve:** Thank you. Bye.

## Eve's Second Call with MSUK

**TC16**

**MSUK – Call2**

**[Identifying data redacted ###]**

**[call length 11:29]**

**SP:** Parts of your medical record with us. Are you okay to proceed?

**Eve:** Yeah, that's fine.

**SP:** Okay, and do you have any conditions where you may need any support with your appointments? Any hearing or sight impairments, learning or physical disabilities?

**Eve:** No, I don't have any of that.

**SP:** Okay, great. Do you take any form of recreational drugs?

**Eve:** No, I don't.

**SP:** Okay. Is anyone else in the room with you while you take this call today?

**Eve:** No, no one else is here.

**SP:** Do you feel safe to have this call at the moment?

**Eve:** Yeah I do.

**SP:** Okay. Can I ask if you or anyone you have come in touch with, has a continuous cough, fever or changes in normal taste or sense of smell?

**Eve:** No, they don't.

**SP:** Okay, and do you?

**Eve:** No, I don't, sorry.

**SP:** Okay, brilliant. Can you confirm that you are sure of your decision to terminate the pregnancy?

**Eve:** Yeah, I'm sure.

**SP:** Would you like any form of counselling at all?

**Eve:** No, I'm okay. Thank you.

**SP:** No problem, our counselling is available at any point, both before and after treatment, if you do change your mind at any point.

**Eve:** Okay.

**SP:** For legal requirements, can you explain to me your reasons for requesting a termination?

**Eve:** I'm studying at the moment, and I don't feel like I could support a child right now. It wouldn't have helped with starting my career. Yeah, it would just be really hard to have anything else to look after right now.

**SP:** I understand. So was it an unplanned pregnancy?

**Eve:** Yeah.

**SP:** Okay. No problem. Well, under the abortion act, your reason comes predominantly under the emotional reason.

**Eve:** Mm-hmm (affirmative).

**SP:** Are you happy if we put here that you're to be emotionally unable to cope and continue the pregnancy, as you're currently still studying and because it was unplanned?

**Eve:** Yeah, yes.

**SP:** Okay, now we just need to find out about your medical history. These questions are about yourself only and no other family members. We do just ask that you be as accurate as you can be as all treatment is subjective.

**Eve:** Okay.

**SP:** I've got here that the first day of your last period is the fourth of May, is that an accurate date or was it estimated?

**Eve:** I actually checked my app and it's the 18th. I made a mistake on the call yesterday.

**SP:** Okay, no problem. That's fine. So, is the 18th quite accurate then?

**Eve:** Yeah.

**SP:** Okay, perfect. Have you had a scan?

**Eve:** No, I haven't.

**SP:** Okay, when was it that you took your last positive pregnancy test?

**Eve:** It's about a week ago.

**SP:** Okay, that's brilliant. The last period that you had, the one in May, was that a normal last period or was it any lighter than usual?

**Eve:** Yeah, it was normal.

**SP:** Okay, brilliant. Do you usually have quite regular periods, at least Every four to six weeks or so?

**Eve:** Yeah I do.

**SP:** Okay, brilliant. Do you have any children at all?

**Eve:** No.

**SP:** Any previous pregnancies, or previous stillbirths, ectopic miscarriage or an abortion before?

**Eve:** No.

**SP:** Do you have any gynae problems, any problems with your womb, your ovaries, any [inaudible 00:02:56] areas?

**Eve:** No.

**SP:** Have you had any pervious surgeries in these areas before?

**Eve:** No.

**SP:** Have you've been told that your fallopian tubes have been damaged or been previously sterilized?

**Eve:** No.

**SP:** Okay. Were you and your partner using any form of contraception when you became pregnant?

**Eve:** No.

**SP:** It's routine of us to advise you of your contraceptive options. They must provide you

with information and answer any questions in relation to these.

For more information have a look at the family planning association website, which is [sexwise.fpa.org.uk](http://sexwise.fpa.org.uk).

**Eve:** Okay.

**SP:** [inaudible 00:03:30] routinely test for sexually transmitted infections. If you would like the testing on the day, we'd contact you with the results within two weeks. If we can't contact you about positive testing, we will contact your GP.

**Eve:** Okay.

**SP:** Just to confirm, have you been using any form of hormonal contraception within the last three months? Anything like the pill, implant or injection?

**Eve:** No.

**SP:** Okay. Just a couple more questions now. Most of these are going to be yes or no questions. Have you Ever been diagnosed with any psychiatric illnesses, any mental health problems?

**Eve:** No.

**SP:** Ever had jaundice or hepatitis?

**Eve:** No.

**SP:** Are you allergic to anything?

**Eve:** No.

**SP:** Are you diabetic?

**Eve:** No.

**SP:** Do you have asthma or any breathing problems?

**Eve:** No.

**SP:** Are you on any steroid medication?

**Eve:** No.

**SP:** Ever had rheumatic Ever?

**Eve:** No.

**SP:** Do you have epilepsy?

**Eve:** No.

**SP:** Do you smoke cigarettes?

**Eve:** No.

**SP:** Ever had any heart complaints or high blood pressure?

**Eve:** No.

**SP:** Do you vape or use an e-cigarette?

**Eve:** No.

**SP:** Ever had a thrombosis or blood clots in the lungs or legs?

**Eve:** No.

**SP:** Ever had a blood transfusion before?

**Eve:** No.

**SP:** Ever had a general anaesthetic so you go into a deep sleep for any surgery?

**Eve:** No.

**SP:** Ever had a local anaesthetic where the area is just numbed with an injection, usually at the dentist, for example?

**Eve:** No I haven't.

**SP:** Okay. [inaudible 00:04:58] your height and your weight please.

**Eve:** I'm five foot six and I weigh nine stone eight.

**SP:** Okay, that's great. Thank you. Have you Ever been tested for something called sickle cell trait or sickle cell disease?

**Eve:** No.

**SP:** Ever taken a herb remedy called St. John's Wort?

**Eve:** No.

**SP:** Ever been diagnosed with a bleeding disorder or a chronic [inaudible 00:05:20]

problem?

**Eve:** No.

**SP:** Ever had inherited porphyria or systemic [inaudible 00:05:24].

**Eve:** No.

**SP:** Brilliant, just to confirm you don't have a contraceptive coil in place at the moment?

**Eve:** No I don't.

**SP:** Okay. Do you have any ectopic symptoms? Any lower abdominal pains? Any bleeding within the last five days?

**Eve:** No.

**SP:** Okay. Ever been diagnosed by a doctor with migraines?

**Eve:** No.

**SP:** Ever had low white blood cells, or low pigment?

**Eve:** No.

**SP:** Ever had anaemia, so low iron?

**Eve:** No.

**SP:** Ever been treated with iron tablets, iron infusions or iron injections?

**Eve:** No.

**SP:** Do you have any other medical conditions?

**Eve:** No, I don't.

**SP:** That's great. Do you take any form of regular medications, is there anything that you take Every day?

**Eve:** No, I don't.

**SP:** Okay. Perfect. If there are any changes to your medical history or the medication you're taking between now and your next appointment, just make sure to mention to the nurse on the day.

**Eve:** Okay.

**SP:** At the moment, Amy, we've got you set down at just over seven weeks. At your current gestation, you are eligible for the early medical abortion. Would it be safe for you to pass the pregnancy at home? So, to have something like the medical abortion?

**Eve:** Yeah, that would be fine.

**SP:** Okay. Would you be able to receive a small package to your home address? This would have the medication and the abortion information enclosed.

**Eve:** Yeah, that's fine.

**SP:** We've got your home address as, ### with the ### post code.

**Eve:** Yeah, that's right.

**SP:** Okay. That's perfect. At your current stage, we'd recommend the early medical abortion. Based off the information provided, we can offer you an appointment without the ultrasound scan. So, that's the telemedicine where we can send the tablets to your home. It's simple as taking a tablet, that ends the pregnancy, followed by [inaudible 00:07:05] and tablets that will cause you to miscarry. You may experience heavy bleeding and cramping, just make sure to have adequate pain relief and sanitary towels. Any medical abortion is between 95 to 99% effective. It doesn't involve any surgery or an anaesthetic. Are you happy for me to continue with the medical abortion?

**Eve:** Yeah, that's fine.

**SP:** Okay, brilliant. So, after this call, I'm going to send you a link containing information about your treatments, the consent form and the aftercare information. It is very important that you read these before your next appointment, which can be completed over the telephone. Do you have access to the internet?

**Eve:** Yeah, I do.

**SP:** Okay. So the next appointment is the announcement of our [inaudible 00:07:47], we'll call you to conduct a full health assessment, which I'll get booked in for you.

**Eve:** Hang on, so, do I have to go to a centre?

**SP:** No. So, the next appointment is to have the telephone call.

**Eve:** All right, okay, sorry.

**SP:** Is that okay?

**Eve:** Yeah, that's good. Thank you.

**SP:** Okay, that's one of our centres, we'll call you to conduct a full health assessment, which I'll get you booked in for. This is to check that it's safe for you to have the abortion with us. There are some complications that will also be explained. Similar to this call, they'll call you from a withheld or a private number, up to two times. If you do miss both calls, you would need to call and rebook a telemedicine appointment. You cannot collect or have the tablets posted until this call has been completed. So, once again, make sure to be in a private and a quiet place for the appointment. You must not be driving or using any form of hands-free. We need to say this to Everyone, but for your safety and so you can legally give your consent. Just make sure to refrain from taking any form of recreational drugs or alcohol 24 hours prior to your appointment. If you do appear to be under the influence at your appointment, it will be cancelled.

**Eve:** Okay.

**SP:** Once again, Even though we know it's unlikely, do you have any form of flights or any travel plans booked in.

**Eve:** No, I don't.

**SP:** Okay, brilliant. We recommend to all clients, that you should not participate in any strenuous activity until you've passed the pregnancy. This simply is all physical activities and sports. All of the aftercare will be explained to you by the nurse. But if in the meantime, you do feel like you need further information, you can have a look at our website. Which is [mariestopes.org.uk](http://mariestopes.org.uk) and it's full of information about the [inaudible 00:09:21] options on there as well. In a second, I'm going to help you get booked into your appointment. Have you absorbed the information I've gone through so far and do you have any questions for me at the moment?

**Eve:** No. That's okay.

**SP:** Okay. Are you happy for me to see when I can get you booked in to speak with the nurse?

**Eve:** Yeah, that'd be great.

**SP:** Okay. Would you prefer to collect the abortion medication from the centre or would you prefer that we just posted it to your home?

**Eve:** Could you get it posted please?

**SP:** Yeah, that's absolutely fine. We have an appointment available for the call with the nurse on ###. Is that day okay or would you like me to look at a different day?

**Eve:** Monday's a good day.

**SP:** Okay. So, they'd either have in the morning or in the afternoon. What kind of time would you prefer?

**Eve:** Could you do morning?

**SP:** Yeah, we'd either have at 8:15, 10 to nine, 9:25, 10 o'clock, 10:35 or 10 past 11.

**Eve:** What was the nine o'clock?

**SP:** 9:25?

**Eve:** Yeah. Could I go for then please?

**SP:** Yeah, absolutely. That one's been booked in for you. How do you prefer the confirmation? Would you like a text message or do you prefer an email.

**Eve:** Text message would be fine.

**SP:** Okay, brilliant, I'll send that out to you in a second. Just to confirm that's ###, you'll call with the nurse.

**Eve:** Okay.

**SP:** As long as everything's okay during that call, everything will get posted out to you on that day. Just keep in mind with the current situation around coronavirus, if we do have to cancel or rebook any appointments, we'll contact you via telephone. If we cannot get through, we'll leave you a message.

**Eve:** Okay, thank you.

**SP:** No problem. If you have any problems with the appointments though, we are here from 7:00 AM to 11:00 PM for any booking or appointment queries. Is there anything else I can help you with today?

**Eve:** No, that's fine, thank you.

**SP:** No problem. Well, we'll speak to you on ###, if not, we're here at any time. [inaudible 00:00:11:12].

**Eve:** Okay, thank you.

**SP:** No worries at all. Take care.

**Eve:** You too, bye.

**SP:** Bye.

## Eve's Third Call with MSUK

**TC16**

**MSUK – Call3**

**[Identifying data redacted ###]**

**[call length 24:03]**

**Eve:** Hello?

**SP:** Hi, can I speak to Eve ### please?

**Eve:** This is Eve.

**SP:** Hi Eve. My name is SP, I'm calling you from Marie Stopes in Central London.

**Eve:** Hi.

**SP:** I'm calling a little bit early. Is that okay or do you want me to call you back?

**Eve:** Yeah, that's fine. Thank you.

**SP:** No problem. Can you just give me the pin on the password please, before we continue?

**Eve:** Yeah. So the password is ### and the pin is ###.

**SP:** Perfect. Thank you. So as I said, my name's SP and I'm planning to do your telemedicine appointment. Are you still happy to go ahead with that today?

**Eve:** Yes, please.

**SP:** Okay, no worries. I'm just getting your details up, okay?

**Eve:** Okay.

**SP:** So what we need to do is go through some safeguarding questions and then go through and just check all your information, to make sure you're still eligible to have a fee done over the phone. Then we'll go through the consent and the medication itself. Okay?

**Eve:** Okay.

**SP:** So safeguarding, we ask everybody the same questions. All the information you give me, it's totally private and confidential. The only time I would want to share any information would be, if you told me anything that made me concerned about your safety, is that okay?

**Eve:** Yeah, that's fine.

**SP:** Thank you. And just bear with me, because I have to type it out as we go along. Okay? And you're having your medication posted to you, is that right?

**Eve:** Yeah, that's right.

**SP:** So I'll just check your address before we start as well. So I've got here that you are at ###. Is that right?

**Eve:** Yeah, that's right.

**SP:** Right. Let's get back to that then. So do you give me consent to continue with the safeguarding questions?

**Eve:** Yeah.

**SP:** Thank you. Is there anybody at home with you at the moment?

**Eve:** No.

**SP:** And you feel safe to have a conversation?

**Eve:** Yeah, I do.

**SP:** And you feel safe to pass the pregnancy at home.

**Eve:** Yeah, I do.

**SP:** And there's no concerns of you receiving the medication to your home address?

**Eve:** No.

**SP:** Do you take any recreational drugs?

**Eve:** No.

**SP:** Including alcohol?

**Eve:** No.

**SP:** Never?

**Eve:** I mean, very occasionally.

**SP:** Okay, that's fine. And have you ever had any social services involvement in your life?

**Eve:** No.

**SP:** And have you ever been diagnosed with any mental health conditions?

**Eve:** No.

**SP:** Do you regularly feel down or depressed?

**Eve:** No.

**SP:** Have you ever harmed yourself or considered harming yourself?

**Eve:** No.

**SP:** And are you in a relationship at the moment?

**Eve:** No.

**SP:** Did you split with a partner in the last 12 months?

**Eve:** Yeah.

**SP:** I'm just updating this. And is your ex-partner the father of the pregnancy?

**Eve:** Yeah.

**SP:** Is he aware that you're pregnant?

**Eve:** Yeah.

**SP:** He is and he's aware about your decisions to terminate?

**Eve:** Yeah.

**SP:** Have you got any concerns about his behaviour? Has he ever harassed you in any way that was face to face, phone call, text message?

**Eve:** No.

**SP:** Has he ever tried to make you feel frightened of him?

**Eve:** No.

**SP:** Has he ever physically hurt you?

**Eve:** No.

**SP:** Has he ever tried to control your behaviour, stop you from seeing your family and friends?

**Eve:** No.

**SP:** Has he ever been emotionally abusive? Called you names, anything like that?

**Eve:** No.

**SP:** And did you always thought that you could consent to sex with him? So say yes and no, whenever you wanted?

**Eve:** Yeah, so I could always consent.

**SP:** Thank you. And are you concerned if your family or community or your ex-partner's family or community found out about your decision, so that you could to come to any harm?

**Eve:** I wouldn't come to any harm, no.

**SP:** And have you undergone any genital cutting for religious or cultural reasons?

**Eve:** No.

**SP:** That's all done. Thank you. So bear with me for one second while I just save that. And then we're going to go through everything just to make sure that you are still eligible to have everything done over the phone, as I said. All right. So I've got here that the first day of your last period was the 18th of May?

**Eve:** Yeah, that's right.

**SP:** Are you pretty sure of that date?

**Eve:** Yeah, I'm sure.

**SP:** And this is the first time you've been pregnant?

**Eve:** Yeah.

**SP:** And you're not aware of any gynae problems that you've got?

**Eve:** No.

**SP:** And have you had any pain or bleeding since you've been pregnant?

**Eve:** No.

**SP:** And were you taking any contraception in the last three months?

**Eve:** No.

**SP:** That's fine. And then just quickly check your medical history. Nothing of note, really?

**Eve:** No, I don't have anything.

**SP:** That's perfect. So just a couple of questions. Do you want to have a chlamydia test included in your pack?

**Eve:** No, thank you.

**SP:** Okay. And is that, have you been tested recently or?

**Eve:** No.

**SP:** You just don't want to know? It's just they ask me to put an answer. So it's just so I can say why you don't want to have the testing done. It's your choice.

**Eve:** Oh, I just thought maybe I don't need to, but do you think it's a good idea to put one in?

**SP:** Well, I just think as women it's just important to get checked regularly. Because the reason we offer chlamydia and gonorrhoea and things like that, are the ones that don't really have any symptoms. So if you split with a partner, it might be worth just checking before you. But you don't have to do it at the moment. If you don't want to, you can wait until all this is over and then you can just go to your sexual health centre and just get it all done. Because it's only chlamydia we can offer you. If you go to the sexual health centre, they'll do everything.

**Eve:** Okay. Yeah, I'll just wait and I'll go to a sexual health centre.

**SP:** Yeah, that's fine. And what about contraception? What are you thinking about sort of moving forward?

**Eve:** I'm thinking about using condoms and using the pill. Yeah. So that's what I've been thinking of.

**SP:** So there's two different types of pill or two

sort of families of contraceptive pill. Basically there's a progesterone only one or there's the combined one. Have you ever been on the pill before?

**Eve:** No.

**SP:** So the combined one contains progesterone and oestrogen and that's the one where you take it for three weeks and then have a week break and bleed in that break. The progesterone one, as it says, only contains progesterone and that's the one that you take continuously with no break. They both don't have any long term effects on your fertility. They both have, what we call the most common reason they fail, is user error. So either you forget to take it, you don't take it in time. You have diarrhoea and vomiting or you take antibiotics or something which can affect it. And then don't protect yourself correctly for seven days following an incident like that.

**SP:** So that's the most common reason why people fall pregnant on the pill. But they are, if used well, very effective. So we can only offer you the progesterone only pill today. Just because with the one that contains oestrogen, it has got more contraindications and more reasons why people can't use it. So you have to have a face to face of that and have your blood pressure taken and things like that. So if you wanted to have the combined one, you need to go to your sexual health centre or your GP. Or if you were happy to try the progesterone only one, we could provide you with that today.

**Eve:** I think I'll just wait to go to my GP and I'll talk with them there.

**SP:** That's fine. So just be cautious, because you can release an egg up to eight days after termination. And I don't know if you've looked into the success rates of condoms and things, but condoms just really... I mean, yes, they're the only ones that can protect you from some STIs, but in terms of you falling pregnant, they're really just not very reliable. They're in the 80s compared to contraception, which is in the high 90s. So just be careful with condoms. Okay?

**Eve:** Okay. Thank you.

**SP:** That's fine. So just make the appointment,

because you can start taking the contraceptive pill as soon as the day after yours. Because you're going to take two sets of medication to complete the abortion and then you can start taking the contraceptive pill as soon as the next day. And so you're protected from straightaway. Because you're not waiting for it to be posted, you could always go and see your GP in the meantime, just so you've got an idea of the timescale of when you can start taking it. Okay?

**Eve:** Yeah.

**SP:** Right. So did you manage to read the consent form that was sent in the email or text message you got?

**Eve:** I've got it with me.

**SP:** Have you read it?

**Eve:** Yeah.

**SP:** You have. Is there any questions about anything that you read?

**Eve:** So I just wanted to make sure that I can take extra painkillers with the pills. That's not going to affect anything that's going on with the pills already, is it?

**SP:** No. So when we get to the medication itself, we will kind of provide you with some codeine as well. So when we go through the process, we'll go through the painkillers and what to take and when. Okay? But we're going to go through the risks now. And then did you read the consent form? Because there's also asked, in the consent form it says things like, I confirm the benefits and risk of available pre-approved alternative treatment.

**Eve:** Yeah, I've read it and everything's fine.

**SP:** Great. So I just need to go through the risks review, because we did that with everybody. Okay? So just to make sure you fully understand everything. So there's a risk that the pregnancy could continue. So assertively, the treatment fails, that happens to one in a 100 women. And we'll give you a pregnancy test that you need to take three weeks after you've taken your medication. Okay? And there's also a risk of retained products. So what that means is when your body tries to pass the pregnancy, a small amount of tissue gets

left behind. And the risk of that happening is less than three in a 100 women. That would also give you a positive pregnancy test. So if you take that test in three weeks time and it is positive, you need to call us up. Because we need to bring you into one of our centres, scan you, find out what was going on and then make a decision based on that scan. Okay?

**SP:** And there is a risk of infection, which is uncommon, less than one in a 100 women experience infection. What you would be looking out for would be anything that has an unpleasant smell, severe tenderness or pain in your lower back and lower abdomen that is either not getting better or increasing, flu like symptoms and high temperature. Okay? When we go through the process, we will go through some things to avoid, to try and help you minimize your risk of that happening. Okay? There is the risk of severe bleeding requiring blood transfusion, that is rare, less than one in a 1000 women experience that. Have you got yourself some maternity or night-time pads to wear?

**Eve:** Yeah, I do.

**SP:** Great. So if you were to soak through two or more of those pads in an hour and that was to happen again for a second consecutive hour, then we would advise you to go to A&E, because we'd be concerned about the bleeding. Okay? And the only other thing that we like to point out, is that if you take the first tablet and then you either change your mind or the treatment fails, and then you refuse any further treatment, that tablet can cause late miscarriage. Or if you did continue to the pregnancy to full term, it could cause fetal abnormalities. Okay. So any questions you want to ask about anything on the consent form?

**Eve:** No.

**SP:** So having gone through the risks. Are you happy with everything and do you give us your verbal consent for us to continue today?

**Eve:** Yeah, I do.

**SP:** Thank you. So as it says, you're going to have two sets of medication. The first is called mifepristone, that is a single tablet that you just swallow with water. And that is a tablet that is going to stop your body producing any

further hormones to the pregnancy. So it stops the growing effectively. Side effects of that one are quite minimal and the most common is feeling sick from it. And if you are sick within one hour of taking that tablet, you need to call us, because we will need to arrange another one for you. You may experience some light cramping with it. You can just take some paracetamol for that and very occasionally you might get a bit of spotting with it as well. If you do get spotting, it's not a problem and you still need to take your second set of medication. Okay. It just may change how you take your second set of medication. Okay?

**SP:** So the second set of medication, you take 24 hours after you've taken your first tablet. That's called misoprostol and that is the medication that is going to make your body pass the pregnancy. So side effects of that tablet, there are a few more, they can make you feel nausea, you can get diarrhoea, you can get sort of fever, like feeling sick, sort of hot and cold, light flushes, shivery and shaky and they can make you feel a bit drowsy as well. Okay? Those side effects only tend to last two to three hours after taking the medication. The other side effect is of course the cramping, because what their job is basically, is to make your uterus contract and cramp and push out the pregnancy. So the cramping is going to last longer, three to four days on average, with most people reporting that the worst of it was within the first 24 hours. And they feel that they passed the pregnancy in the first 24 hours as well.

**Eve:** Okay. With the first pill?

**SP:** Sorry?

**Eve:** With the first pill?

**SP:** The second. The first one, you're not going to get much.

**Eve:** I thought you said-

**SP:** You're not really going to notice much, it's going to be after you've taken the second set. Okay?

**Eve:** Okay. I'm sorry.

**SP:** So there are six tablets in that box in total and you need to take the first four initially. The

way we recommend that you administer them is taking them vaginally. So that is just, a case of just, go to the bathroom, go for a wee, wash your hands and then they're quite small, a fingertip size. And you just need to place them into the vagina one after the other, but you do need to have all four in there at the same time and you only need to push them up as high as you can comfortably go. Okay? We don't expect you to be able to get them anywhere really specific. And then they will just dissolve and absorb into your system.

**SP:** And the reason we recommend that you place them vaginally, is that first set of symptoms I was talking about. The nausea, feeling shivery and shaky. Those side effects tend to be milder when they're placed vaginally. So what would happen, is that your body would just absorb them into your system and then they would start to work. So if three hours passes, since you have taken those tablets and you still have no bleeding, then you can take the remaining two tablets. If you start bleeding, then you don't need to take them. And we just ask that you dispose of them safely by taking them to a chemist. Okay?

**Eve:** Okay. Yeah.

**SP:** So the other way you can administer them, is for if A, you're just really uncomfortable with doing it vaginally or B, if you are actively bleeding from the first tablets. So with the first you can use your judgment. So if you just have a little bit of spotting and then you have nothing for 24 hours, that's fine. We were just talking about if you're bleeding at the time of that you want to insert the tablets. Because what we're concerned about, is that if you put them in vaginally and you're bleeding, that the blood is going to wash them away before they have time to take effect properly and then that could affect how well the medication works. But as I said, if you just have a little bit of spotting and then nothing for 24 hours, that's not going to happen. So that should be fine.

**SP:** So the other way is called buccally. And what that means is placing them in your mouth, tucked down between your cheek and your gums. So you would put all four tablets in at the same time, two on each side, but you must let them dissolve for 30 minutes. So no chewing, no swallowing, no washing them down with water in that time.

And then obviously if you're doing it because you're bleeding, then you wouldn't need the remaining two tablets anyway. Does that all make sense?

**Eve:** Yeah, that makes sense.

**SP:** Great. So then what you're going to expect once you start bleeding, is three to four days of reasonably heavy bleeding with clots and cramping. However, as I said, most people report that the worst of it was within the first 24 hours and they feel that they passed the pregnancy in the first 24 hours. So pain relief, what I advise you to do, is take paracetamol and ibuprofen and then we are going to give you two codeine tablets as well. So take the paracetamol or ibuprofen before you even administer those second set of tablets. And then I would like you to take them regularly throughout the day for that first 24 hours. Because paracetamol and ibuprofen are both medications that work best when taken regularly. But effectively don't keep waiting for the pain and then take them, just take them at their regular intervals to keep a good level of medication in your system. Then if you feel that you've taken as many kind of paracetamol and ibuprofen as you can, and you're still feeling like you need something else, then you've got your codeine tablets to take.

**Eve:** Okay. So I don't need to take the codeine really until I finished one-

**SP:** You can take codeine alongside ibuprofen and paracetamol, because it's a different sort of family of medication, but just because we only give you two tablets, just don't take it too early. So if you've taken your paracetamol and your ibuprofen at nice regular intervals and you feel like you still need something else, then take your codeine tablets. Okay?

**Eve:** Yeah.

**SP:** And then it's also good for you to have something like a hot water bottle or a heat pack to put on your abdomen as well, to help with the cramping. But you can... What was I going to say about the codeine? Sorry, I've lost my train of thought. Just don't take it too early, but also don't try to be too brave either. When you feel you need it, just take it. So what you're going to probably expect in that first 24 hours of when you thought that you might

need to take the codeine. Is you're going to reach a point where the cramps kind of are a little bit more intense. You might start feeling some pressure and that is probably the point where your body is trying to actually pass the pregnancy. So you might want to just go and sit on the toilet at that time and just allow things to pass.

**Eve:** Okay. How long does it usually take to get to that?

**SP:** It really varies from person to person. So it's really difficult to answer that question, I'm afraid. But just kind of listen to your body, rest when you need to rest. When you feel well, just try and get about and distract yourself, carry on with your day-to-day bits and pieces. Try and stay well hydrated, eat little and often, have things like sweet tea, hot chocolate. Just so you've got a bit of sugar in your system, which can make you feel a bit better. Are you going to have someone with you? That's what I was going to ask you as well.

**Eve:** I'm going to be on my own, but I feel safe where I'm doing it. So I've got time on my own, so it's all right.

**SP:** Okay, that's fine. Sorry, just back to the bleeding. So three to four days of reasonably heavy bleeding. You can bleed for up to two weeks, but it should be getting progressively lighter. And some people find that they spot until their next period. Okay? So things to avoid, no aspirin, because it's a blood thinner. No alcohol for 48 hours, no bath for 48 hours, just showers please. No sex or swimming for two weeks, no heavy lifting or strenuous exercise for two weeks. And if you use tampons, just none until your next period. Okay?

**Eve:** Okay.

**SP:** Any questions about anything?

**Eve:** I think you've answered most of my questions.

**SP:** So there is also a 24 hour aftercare line as well. So you should have that number in your aftercare advice on that link. So if at any stage you're concerned about anything or you're just unsure about anything. You can call that number and a nurse is there to answer the phone 24/7. Okay?

**Eve:** Okay. Thanks.

**SP:** So you've got that kind of backup as well. All right, so your pack will be posted out at four o'clock today. And then if you haven't received it in kind of five to seven days, please give us a call and we'll chase it up for you. But hopefully, it's just because of the COVID situation we've been advised that it's been taking a bit longer, but obviously things are easier now, so hopefully it will be with you before then.

**Eve:** Okay. So three to five days then?

**SP:** Pardon?

**Eve:** Three to five days it'll be here?

**SP:** Yeah. Three to five days and it should be with you. Because it's going to be sent today and it will be sent first class and should be with you by the end of the week.

**Eve:** Okay. That's great. Thank you.

**SP:** Okay, no problem. All right. Any further questions before we finish?

**Eve:** No, that's it.

**SP:** Okay, all right. You take care, okay? Hope everything goes okay.

**Eve:** Thank you, you too.

**SP:** All right. Thank you. Bye.

**Eve:** Bye.

## Saskia: Summary

After making twenty calls we realised that it didn't matter what reason our volunteers gave for wanting an abortion, that in each case this was positioned by the service provider as being an emotional issue and thus the abortion could be granted under Ground C mental health. Our initial set of calls had used the usual reasons which women give for their abortion: autonomy, it's my body my choice; economic, I can't afford it; education, I need to finish my studies; career, I've just started a new job; family complete, we already have three children, that's enough; timing, it's just not convenient right now; unplanned, I didn't intend this and I don't want to be pregnant; and relationship, he's just not the right partner for me.

In creating the persona for Saskia, we wanted to push the boundaries a bit more to explore just how far abortion providers would bend the mental health clause of Ground C. Saskia presents as a pregnant woman with a gestational age of seven weeks one day. Her reason for choosing an abortion is that she doesn't want to be pregnant during an upcoming beach holiday. Both BPAS and Marie Stopes UK accept this as a valid reason and engage with Saskia in a longer discussion about abortion by choice being legal. In this transcript BPAS tells Saskia that any reason other than the sex of the baby is a valid reason, it just needs to be attached to a legal reason, which they suggest is that Saskia is just not emotionally ready for a pregnancy right now.

## Saskia's First Call with BPAS

TC20

BPAS - Call1

[Identifying data redacted ###]

[call length 12:57]

**Saskia:** It's the ### July, 2020, ### in the afternoon and ringing BPAS.

**Speaker 2:** Thank you for calling BPAS. If you have not been contacted by us, assume your appointment is going ahead as planned. You will be contacted by the clinic if this changes. This booking line is used for urgent queries and bookings. We thank you for your patience during this busy period. If in the last seven days you have developed a new continuous cough

or a high temperature, please inform the advisor when you're connected. If you already have an appointment booked in a clinic, please do not attend. If this affects you and you have not already done so, please seek advice from NHS 111 online and call us back to reschedule if necessary.

**Speaker 2:** We provide a confidential service and any information provided will be kept on a safe and secure system. Calls may be recorded for training and quality purposes. We advise that you have your GP details to hand. In order to provide your care we may need to share some information with the NHS or other providers. We would like to reassure you all information received will be kept confidential. We would generally advise that you don't bring children with you for your appointments. However, if that is difficult for you, please inform the advisor.

**Speaker 2:** We would like to send you communications about our other work and ask you about your experience with BPAS. An advisor will ask your permission at the end of the call. You may withdraw permission at any time. Please press one for a new booking, two for general information, three if you're an.

**Speaker 2:** We advise that you have your GP details and a pen and paper to hand. Please disclose all medical conditions. If we do not have the correct details, it may delay your treatment.

**SP:** Good evening, you're speaking to SP. How can I help?

**Saskia:** Yeah, hi, this is Saskia. I found out that I'm pregnant and I wanted to ask if I could get help.

**SP:** Okay. Let me take some information from you. Have you called us before?

**Saskia:** No, I haven't.

**SP:** No. And did you find us online?

**Saskia:** Yeah, I did.

**SP:** Okay, so let's look this and see what we can do for termination of pregnancy for you. Can I start by asking your first name please?

**Saskia:** Yeah. So my first name is Saskia, ###.

**SP:** ###, your surname, please.

**Saskia:** ###.

**SP:** Yeah, ###?

**Saskia:** Yeah. So ###

**SP:** Double #.

**Saskia:** ###, yeah.

**SP:** ###?

**Saskia:** ###.

**SP:** Okay. And what is your date of birth, please?

**Saskia:** And that's the ###.

**SP:** Yeah, ###. Your postcode, please?

**Saskia:** That's ###.

**SP:** Yeah?

**Saskia:** ###.

**SP:** Okay, just a second while I find you.

**Saskia:** Thank you.

**SP:** Okay. Are you register with a doctor's, Saskia?

**Saskia:** Yes, I am.

**SP:** Okay. So have you moved house recently?

**Saskia:** Some months ago,

**SP:** Months ago. Have you got your last postcode?

**Saskia:** Pardon?

**SP:** Have you got your previous postcode?

**Saskia:** Oh, gosh.

**SP:** No, don't worry about it. That's fine. Can you tell me what's your address now, please?

**Saskia:** Of course, yeah. So my address now is ###.

**SP:** ###.

**Saskia:** Yeah.

**SP:** ###, is it?

**Saskia:** Yeah, so it's-

**SP:** Are you at ###?

**Saskia:** Yeah.

**SP:** Okay, so what number?

**Saskia:** ###.

**SP:** ###?

**Saskia:** Yeah.

**SP:** Okay. And what's your doctor's postcode, please?

**Saskia:** Wait, that's S-

**SP:** Is it SE16?

**Saskia:** Yeah, yeah, it's SE16.

**SP:** What are they called?

**Saskia:** They're called Park Medical Centre.

**SP:** Sorry, say again, what's it called?

**Saskia:** Park

**SP:** Park Medical Centre.

**Saskia:** Yeah.

**SP:** Okay. Can we contact them if we need to or not?

**Saskia:** Is it possible to keep it confidential?

**SP:** Yeah, I won't contact them, but you need to contact them yourself at some point and find your NHS number because it's not showing on here.

**Saskia:** Okay.

**SP:** Okay, so first of all, I need a mobile number for you. Have you got one?

**Saskia:** Sure. So it's ##-

**SP:** ####?

**Saskia:** ###, sorry.

**SP:** ###, yeah.

**Saskia:** And then ###.

**SP:** Yeah. So ###, yeah?

**Saskia:** Yeah.

**SP:** Can we call you on this number, leave voicemail, and send you text message reminders from a private number?

**Saskia:** Yeah, that's fine.

**SP:** Have you got an email address please?

**Saskia:** Yeah. So my email address is ###

**SP:** Yeah.

**Saskia:** ###, and then the number ###.

**SP:** Yeah.

**Saskia:** And then my first name, Saskia, ### and then ###, at yahoo.com.

**SP:** Okay. So it is ### at yahoo.com, yeah?

**Saskia:** Yeah, that's right.

**SP:** Would you like to receive information of our fundraising and campaigns by email, text or phone, or would you prefer not to?

**Saskia:** Prefer not to.

**SP:** No problem. And following your procedure, they may contact you by email or text to ask for feedback about your treatment experience. Is that okay or not okay?

**Saskia:** That's fine, yeah.

**SP:** Okay. And have you got a pen and paper ready?

**Saskia:** One second, yes.

**SP:** Thank you. Okay, please write this down, it's your reference number. You're going to need this. Every time you call us, you must give us this. It's ####.

**Saskia:** ###, yeah.

**SP:** ###.

**Saskia:** Okay. Yeah.

**SP:** Can you think of a password for the booking? Give me any password. It can be a number, colour, place, whatever you want.

**Saskia:** Okay. Can it be ###?

**SP:** ###, yeah?

**Saskia:** Yeah.

**SP:** Okay. I'll put down ###, please don't tell anyone about your password.

**Saskia:** Okay.

**SP:** Can you tell me when your last period started?

**Saskia:** Yeah. Wait, let me just check. I've written that down. So that was the 25th of May.

**SP:** Okay. And how tall are you? What's your height and your weight, please?

**Saskia:** So I'm one meter, 73.

**SP:** Yeah.

**Saskia:** And I think I should be about 65 kilos, yeah.

**SP:** Okay. Do you have any medical problems we should know about?

**Saskia:** No, occasional skin problems occasionally, but nothing serious.

**SP:** What, eczema, you mean?

**Saskia:** Yeah. Something like that but not very serious.

**SP:** Well I'll write down eczema, okay. Do you

take any medication at all?

**Saskia:** No.

**SP:** Okay. And have you got any special needs or disabilities?

**Saskia:** No.

**SP:** Asthma or allergies?

**Saskia:** No.

**SP:** Have you given birth by Caesarean before?

**Saskia:** No.

**SP:** Have you taken a test to see if it's positive?

**Saskia:** Yes, I have.

**SP:** Okay. So I just need to say, Saskia, so I just want to confirm this again. Your first name is ###, surname ###, yeah?

**Saskia:** Yes.

**SP:** Are you staying at ### temporarily?

**Saskia:** Yeah. I'm just kind of in transition at the moment. It's a bit of a funny situation, but yeah.

**SP:** Okay. But you are registered with a doctor, though, aren't you?

**Saskia:** Yeah, yeah, yeah, I've registered with them. I just haven't been there because I've just-

**SP:** Okay. Can you do me a favour? I mean, first of all let me tell you what appointments are available and I'll tell you, just wait a second while I find you an appointment.

**Saskia:** Okay, thank you.

**SP:** I'm just looking. So, just a second. So what it is is everyone has to have a consultation before they have their treatment. And some of the providers of abortion in your area, they do a telephone consultation whereby they can, after they talk to you, if everything is okay, they may send you pills by post so you can do the tablets at home yourself, and others will see you for face to face and do a provisional same-day consultation and treatment. Which one do you prefer?

**Saskia:** By post would be probably the best way.

**SP:** Fantastic, okay. So let me take some details off you. First of all, I need to give you some times. You tell me which one is better because there's more than one company that does abortion. So if you go to BPAS, which is ourselves, our appointments would be Thursday, 10 o'clock or 11 o'clock or all day through the day. If you want to go to Marie Stopes, which is another clinic, their appointments are a little different. They've got appointments available tonight and tomorrow, from like, say, eight o'clock, nine o'clock, but their first appointment is a screening appointment, which means after that they will give you a consultation face to face or over the phone to start off, to go from there. So, first of all, would you want to go with Marie Stopes or with us, with BPAS? You've got to tell me that and then I'll tell you the rest.

**Saskia:** Yeah. So BPAS would be, I would prefer that.

**SP:** BPAS, okay? Okay, so now it gives you time booking with BPAS to phone your doctor and find your NHS number because it might be needed, okay?

**Saskia:** Okay.

**SP:** So are you free on Thursday, 10 o'clock in the morning?

**Saskia:** Would it be possible to have an hour later? You said 11 is a possibility on Thursday?

**SP:** Yeah. You can have as late as you like, because they can call your sometimes. Shall we say 12?

**Saskia:** Yeah, 12 would actually be even better. Yes, then I can call-

**SP:** Okay, so I've booked a 12 o'clock. So that mean the nurse is going to call you sometimes between half past 11 and one, because they never call you exactly bang on time, okay?

**Saskia:** Yeah.

**SP:** So when she calls you, she calls you from a private, withheld number, okay?

**Saskia:** Yeah.

**SP:** So then she'll call you, like I say, it's between between half 11 and one, and she'll ask you, first of all, she'll call you on ###. She'll ask you for your reference number ###, okay? And she'll ask you for your password, which was, let me see, ##.

**Saskia:** Yeah.

**SP:** And then she'll talk to you for 30 minutes, 40 minutes, ask you lots of medical questions, okay, and then she'll tell you exactly what's going to happen, because she may send you the pills by post.

**Saskia:** Okay.

**SP:** So between now and then if you can find your NHS number, that'd be good, but otherwise I've just emailed it to you. So you're all booked in and you can ask the nurse any of your medical questions you want, okay?

**Saskia:** Mm-hmm (affirmative).

**SP:** So you're booked in for Thursday from half past 11 onwards, is that okay for you?

**Saskia:** Yeah, sure, that's fine. Thank you very much for your help, I appreciate it.

**SP:** No problem at all. All right, so you take care then. Thank you for calling.

**Saskia:** Yeah, thank you, thank you, bye.

**SP:** Bye.

**Saskia:** Bye.

**SP:** Bye.

## Saskia's Second Call with BPAS

TC20

BPAS - Call2

[Identifying data redacted ###]

[call length 32:38]

**Saskia:** Hello?

**SP:** Hello, can I speak to Saskia?

**Saskia:** Yeah, that's me. Hi.

**SP:** Hi, Saskia. My name is [SP 00:00:00:10] I'm the midwife calling from BPAS.

**Saskia:** Yeah.

**SP:** Hi.

**Saskia:** Hi.

**SP:** You have an appointment to do your consultation. Do you have time to do that now?

**Saskia:** Yeah, absolutely. That's fine. Thank you.

**SP:** Okay. Okay. Saskia, I'm just going to start with some basic information. Can I please take your surname and your date of birth?

**Saskia:** Yeah, my surname is ###.

**SP:** Okay.

**Saskia:** And the date of birth is the ###.

**SP:** Lovely. And your password?

**Saskia:** My password is ###.

**SP:** Okay, lovely. So it takes about half an hour to do your consultation.

**Saskia:** Mm-hmm (affirmative).

**SP:** And in doing the consultation, I do ask quite a lot of questions some of them medical, some of them personal, and everything you disclose to me is completely confidential. So we don't have contact with your GP or the NHS in any way. We only notify them if you disclosed something where we feel like you're in danger or someone else is in danger.

**Saskia:** Okay.

**SP:** Okay? So I'm just going to start with some basic information. Can I take your marital status?

**Saskia:** Yeah, I'm single.

**SP:** With or without a partner?

**Saskia:** I'm in a long-term relationship.

**SP:** Okay. And your country of birth?

**Saskia:** Belgium.

**SP:** Belgium, okay. And your ethnicity?

**Saskia:** I'm white.

**SP:** Okay. And your sexual orientation or would you prefer not to say?

**Saskia:** No, that's fine. I'm straight.

**SP:** Okay. And do you have any religion?

**Saskia:** Nope.

**SP:** And any disability?

**Saskia:** Nope.

**SP:** Okay. Bear with me just one second, Saskia. I just need to update everything on here.

**Saskia:** Mm-hmm (affirmative).

**SP:** Sorry. I'll be one second. Just takes a minute. Okay. So double checking some of the information that I have on the system here.

**Saskia:** Yeah.

**SP:** I have you addressed at the ###.

**Saskia:** Sorry?

**SP:** Is that correct? I have you addressed out of the ###.

**Saskia:** No, that's not correct at all. I'm sorry there must have been a mistake. Oh gosh. Can I, shall I give you my address again?

**SP:** So one is I have ###.

**Saskia:** Yes. ###. Yeah. [crosstalk 00:03:33] And it's ### Yes.

**SP:** But what is, does ### ring any bells to you?

**Saskia:** No.

**SP:** No. Okay. Let me...

**Saskia:** Sorry about that. That makes no sense. No, I don't live in ###.

**SP:** So let me just ask you. Because sometimes it's the way that the address has been written. Okay? So some people state that it's ### or it is ###?

**Saskia:** Yeah. It is ###. Yeah.

**SP:** Okay. So ###?

**Saskia:** Yeah.

**SP:** Okay. So that's why I think, that's an unusual way of an address, to be honest with you.

**Saskia:** Okay.

**SP:** The post code is ###.

**Saskia:** Yeah, that's correct.

**SP:** Okay. And your email, I have done a ###@yahoo.com.

**Saskia:** Yup, perfect.

**SP:** The spelling of your surname. I have ###. Is that correct?

**Saskia:** Yeah, that's right.

**SP:** Okay, great. I just wanted to check on that to make sure, I need to take down an emergency contact for you.

**Saskia:** Sure.

**SP:** Who would be the person that you would want me to contact for you in an emergency?

**Saskia:** That would probably be my partner, ###.

**SP:** Okay. What's your partners... So your partners name is ###?

**Saskia:** Yup.

**SP:** And his surname?

**Saskia:** ###.

**SP:** Okay. And do you have contact number on hand for him?

**Saskia:** Yeah, sure. Just let me get that up.

**SP:** Sure, sure.

**Saskia:** Okay. So that's ###?

**SP:** Yep.

**Saskia:** ###.

**SP:** Okay, lovely. And is he aware of the pregnancy?

**Saskia:** Yeah, he is aware.

**SP:** He is. Okay. And what about contact with you, are you happy if we don't get hold of you on the telephone for number one, us to leave a voicemail message?

**Saskia:** Yeah, that's fine. I'm not a hundred percent sure if I've actually activated my voicemail. I think I deactivated it some time ago because I was getting tired of listening, but text is fine. Text is fine or anything else is great. Calling is fine, yeah.

**SP:** Email?

**Saskia:** Yeah, email's fine. [crosstalk 00:06:14] Yeah. That's all fine.

**SP:** Do you want us to tell your GP that you've been BPAS or would you prefer not to?

**Saskia:** Maybe I'd prefer not to. Yeah.

**SP:** Yeah, sure. There's no reason why we normally do tell them, but obviously if you prefer some people like for them to know, some people don't want them to know and that's absolutely fine.

**Saskia:** Yeah.

**SP:** Okay. Do you have any allergies?

**Saskia:** No, I don't.

**SP:** Okay. So can you tell me a little bit about why you decided to seek an abortion?

**Saskia:** Okay. Yeah. This probably sounds, oh, this is a bit embarrassing actually. So basically, I'd be more than happy to have children in the future and stuff like that. And we've discussed that and we want children, but just not at this particular point in time because I've just, so we've just literally like booked a holiday and we were just like quite confined during the lockdown. And it's been, I mean, we're both all right, but it's just been a bit emotionally draining, all these restrictions and everything. And we were just so looking forward to this holiday and I just want to.. We just wanted to really focus on this holiday and just have a good time and not, I just didn't want to worry about looking pregnant on the beach and all that. I just, it's just so bad the timing right now.

**SP:** Okay. Okay. When is the holiday?

**Saskia:** The holiday is in late August.

**SP:** Okay. But you just, as a midwife myself, are you aware that you probably will not look pregnant?

**Saskia:** Yeah. I mean, I don't know. I don't know whether I would or not. I just don't want to really deal with any aspect of the pregnancy just now at this point in time. And I was just, it's not just looking pregnant. It's probably just whatever, morning sickness and anything. I've been feeling, I mean, it's been all right so far I just felt a bit queasy in the morning. And I just do not want to deal with that, with all of that right now.

**SP:** It sounds to me that the individual reasons you're giving come down to you just not being emotionally ready for a pregnancy right now.

**Saskia:** Um.

**SP:** It sounds, they are all extremely valid. Any reason that you ever give is always going to be valid for you. So whether it's physically with regards to however you look or feel, with regards to nausea, again all your travel plans, it sounds maybe like a physical, emotional time that you're not ready for pregnancy right now.

**Saskia:** Yeah, probably. Yeah.

**SP:** Yeah?

**Saskia:** Probably something like that. Yeah.

**SP:** Yeah. Okay. I mean, I don't want to put words in your mouth. What I have to do is attach what you tell me to a legal reason.

**Saskia:** Oh, okay.

**SP:** Exactly. So when you, I just wanted to give you the right information, but any reason other than the sex of the baby is a valid reason to us, but to attach it to a legal reason, it sounds like emotionally it's not the right time. Because it doesn't necessarily sound like it's financial, possibly slightly physical, it doesn't sound maybe mentally, like you're not ready.

**Saskia:** Yeah. No. I mean, as I said, we talked about it and we definitely, definitely want children in the future.

**SP:** Yeah.

**Saskia:** It's just so, I mean, you know how it is with like the lockdown and everything. It's just been like, I mean, it's not.. Like we've been pretty privileged. It's been harder for many other people, but it's just like, yeah. It's just so, the timing is just so not perfect. You know what I mean? Yeah.

**SP:** Okay. Okay. That's absolutely fine. Okay. So what I'm going to do now is run through a medical history with you. It does involve me asking lots of questions just to establish medically you're fit for our treatment.

**Saskia:** Okay.

**SP:** I have down on the system here that your last period was the 25th of May.

**Saskia:** Yup.

**SP:** How accurate is that date?

**Saskia:** It's very accurate. I'm very, very fastidious with these things. I write it down. Yeah.

**SP:** Okay. Okay. And was that a normal period for you?

**Saskia:** Yup, very normal.

**SP:** Okay. And normally, how many days does your period last?

**Saskia:** So it's seven days. Yeah. It's pretty regular seven days. Yeah.

**SP:** Okay. And how many days normally, do you know how many days there are between your periods? Are we talking about like roughly every 28 days? Every 30 days?

**Saskia:** I think it's 28. I'm very, very, very regular, so I think it's 28 days, yeah.

**SP:** Are you?

**Saskia:** Yeah. Yeah.

**SP:** Okay. Sure. Sure. Okay. And including this pregnancy, how many times have you been pregnant?

**Saskia:** This is the first time.

**SP:** Okay. And you mentioned a little bit that you're suffering with some nausea, but I want to ask you about any abdominal pain or bleeding in this pregnancy. Are you having any of those?

**Saskia:** No, not at all. And the nausea. It's just it's so-so, it's just like when it's almost like a little hint of it.

**SP:** Yeah. Yeah. Okay. I'm going to assume you've not had a scan in this pregnancy?

**Saskia:** No.

**SP:** Okay. Have you ever had any operations in your life?

**Saskia:** No, I haven't. I've been lucky.

**SP:** Brilliant. Never being put to sleep under general anaesthetic

**Saskia:** No, I haven't.

**SP:** Okay. Do you take any medicines prescribed to you by your GP?

**Saskia:** No.

**SP:** Any medicines that you buy and take on a regular basis from over the counter?

**Saskia:** No.

**SP:** Okay. So now what I'm going to do is I'm going to read through lots of different medical conditions. Some of them you'll have heard of before some of them you wouldn't have, which is absolutely fine, but I want you to tell me if you've ever had any of these conditions in your life.

**Saskia:** Okay.

**SP:** So asthma, diabetes, breathing problems?

**Saskia:** Nothing, no.

**SP:** High blood pressure, heart disease, or heart valve problems?

**Saskia:** No.

**SP:** Heart attack, strokes, or migraines?

**Saskia:** No.

**SP:** Blood clots, bleeding disorders, or clotting disorder?

**Saskia:** No.

**SP:** Anaemia, sickle cell, or thalassemia?

**Saskia:** Nope.

**SP:** Seizers, fits, or epilepsy?

**Saskia:** No.

**SP:** Brain tumours, mental health problems, adrenal problems?

**Saskia:** Nope.

**SP:** Liver, gallbladder, or gastrointestinal problems?

**Saskia:** No.

**SP:** Thyroid issues or cancer of any kind?

**Saskia:** No.

**SP:** When did you last have a smear test?

**Saskia:** Wait, so that would have been the end of 2019. So I think it must've been December or something. Yeah.

**SP:** Sure. And was it a normal result?

**Saskia:** Yup, just normal.

**SP:** Have you ever had an abnormal result or treatment to your cervix?

**Saskia:** No.

**SP:** Any fibroids in your uterus or abnormally shaped uterus?

**Saskia:** Nope.

**SP:** Pelvic infection, sexually transmitted infection?

**Saskia:** No.

**SP:** Hepatitis, HIV or AIDS, or any other medical conditions?

**Saskia:** Nope.

**SP:** Are you a smoker Saskia?

**Saskia:** No, I'm not.

**SP:** Do you ever drink alcohol?

**Saskia:** Just every now and then, but not much at all.

**SP:** Okay. Have you ever taken any recreational drugs?

**Saskia:** No.

**SP:** Okay. And were you using contraception when you got pregnant?

**Saskia:** So we use condoms. Yeah.

**SP:** Okay.

**Saskia:** And I'm afraid that it, I think it was that, yeah, it was that time when we had a little accident. Yeah. But normally we use condoms, yeah.

**SP:** Do you mean an accident with the condom or an occasion when you did not use a condom?

**Saskia:** We, it, basically it split. Yeah.

**SP:** Okay.

**Saskia:** Yeah.

**SP:** Sure, sure. Fine. So based on your medical history, you're obviously eligible for treatment with us. You're very healthy. You're very well. And no reason as to why treatment can't be given.

**Saskia:** Yeah.

**SP:** We have the option of pills, which we can either send you by post or you can collect them from a clinic. Do you have a preference?

**Saskia:** Would it be possible to send the tablets by post?

**SP:** Yes, of course. So they normally arrive within three to four days maximum.

**Saskia:** Okay.

**SP:** Okay? Do you know much about the tablets that we do?

**Saskia:** Not all that much. I know a little bit, but not in detail. I just, I know that there's two different medications or something, but that's all I know.

**SP:** Yeah.

**Saskia:** Yeah.

**SP:** Yeah. Yeah. Okay. So what I'll do now, just to let you know, once our call is finished have a look at your email, because I'm going to be sending you through a step by step guide on how to do these tablets.

**Saskia:** Okay.

**SP:** With some contact details, it's a very good leaflet that I want you to read.

**Saskia:** Uh-huh (affirmative).

**SP:** If you follow the guide, you cannot get it wrong. And I'll send you off your consent form, which I'm going to be doing over the phone now, which will just be your sign-in.

**Saskia:** Okay.

**SP:** You mentioned you don't mind having texted so that we can send you some text information about when to expect the delivery of your package.

**Saskia:** Yup, that's fine.

**SP:** So it kind of tells you what day to expect the pills to arrive.

**Saskia:** Mm-hmm (affirmative).

**SP:** Okay?

**Saskia:** Yup.

**SP:** So once you get your package, obviously you'll get the text messages then the package will arrive in one package, which will have everything in it that you need. Okay?

**Saskia:** Okay.

**SP:** Now, inside this package, you will have three different sets of medications.

**Saskia:** Okay.

**SP:** And one of them, the first box is some painkillers and these are quite strong painkillers. They are Codeine.

**Saskia:** Okay.

**SP:** And Codeine is a type of painkiller that can make you a little bit drowsy. They are stronger than paracetamol and ibuprofen, but you are more than welcome to also take paracetamol and ibuprofen.

**Saskia:** Okay.

**SP:** So what some women do is they just start off when they start to get a little bit of pain, they start off with paracetamol and ibuprofen. And then if the pain begins to get a lot stronger, they then introduce the Codeine. And that's the normal pathway.

**Saskia:** Okay.

**SP:** Okay? So that's your first box of tablets. Your second box of tablets, there is one tablet inside of a box. It is a single yellow tablet called mifepristone.

**Saskia:** Okay.

**SP:** And it is a tablet that on the day that you receive the medication you are going to swallow that tablet with some water on that day.

**Saskia:** Mm-hmm (affirmative).

**SP:** And that is the tablet that is slowly going stop the hormones of the pregnancy, but you probably won't have any pain or bleeding from that first tablet.

**Saskia:** Okay.

**SP:** Because what it's doing is stopping the pregnancy on the inside. There's no real, sometimes evidential side effects from that. Some women get a little bit of nausea because it's a hormone.

**Saskia:** Yeah.

**SP:** Some women, 5% of women will get a little bit of a bleed, and that's very normal. All of that is normal.

**Saskia:** Okay.

**SP:** Okay?

**Saskia:** Yeah.

**SP:** So that's two boxes, you've got your Codeine and then you've got your first tablet, which you follow on the day. So that tablet that you swallow on the day takes 24 hours to work.

**Saskia:** Mm-hmm (affirmative).

**SP:** So you need to allow that 24 hours to work. And then once that time has passed, you then can pick a time that day. It can be that evening or straight after the 24 hours have past when you're going to start the last set of tablets that you have in this box.

**Saskia:** Okay.

**SP:** And these are what's called misoprostol, there are six tablets inside the box.

**Saskia:** Mm-hmm (affirmative).

**SP:** And what you're going to do is you're

going to take four tablets out of the box to start with, and you're going to place four tablets inside your vagina.

**Saskia:** Okay.

**SP:** Like you would with a tampon.

**Saskia:** Yup. Yup.

**SP:** Okay? And the reason for you, I recommend you'll see some images about putting them in your mouth because you can put them in your mouth, but what I recommend for you is that you put them in your vagina because you've been feeling sick and think these tablets will make you feel more sick if you put them in your mouth.

**Saskia:** Oh, okay. Yup.

**SP:** So they work exactly the same, whether you put them in the vagina or the mouth. So for you, I definitely recommend vagina.

**Saskia:** Okay.

**SP:** Okay? And you literally, you go down to the toilet, you pass urine and you push the tablets up as far as they can go.

**Saskia:** Okay.

**SP:** Okay?

**Saskia:** Mm-hmm (affirmative).

**SP:** So once those four tablets are in place, they will begin to dissolve. Once they dissolve you then at some point will stop, maybe cramping and bleeding, but three hours after you've put these first four tablets in your vagina I want you to take the last two tablets and pop those inside your vagina as well.

**Saskia:** Okay. Will there be a problem with them staying there? If you know what I mean? Like if I bleed, will that be a bit of an issue to keep them there?

**SP:** Generally not. Generally, no. I mean, if you are sitting on the toilet and kind of bearing down of any kind, sometimes it can push them out. So women alternate them, sometimes the first bunch happens they put in their vagina, and the second tablets they put underneath the top lip of their mouth to dissolve.

**Saskia:** Okay.

**SP:** If they're feeling quite sick, they just pop them in the vagina as well. Normally the vaginal wall keeps the tablets in tight. For most women they stay in, but it's not a problem if you notice that one has fallen out, that's absolutely fine. But they normally dissolve after 20 minutes of being put inside the vagina.

**Saskia:** Yup.

**SP:** But generally it works very well. So even if you'll be bleeding after the first four, I still want you to put the last tablets in the vagina, the last two tablets. Now expect that you can get heavy bleeding, blood clots, and little bits of tissue.

**Saskia:** Okay.

**SP:** Okay? And it can be very painful. It can, which is why we give you the Codeine and we tell you to buy some paracetamol and ibuprofen. Okay?

**Saskia:** Mm-hmm (affirmative).

**SP:** Now, after a few hours, the pregnancy will come out and the bleeding will start to die down. And then you'll notice that once the bleeding dies the pain will slowly start to die down as well. And you'll bleed for a minimum of four days afterwards up to a maximum of six weeks on and off. Okay? Most women do not bleed for six weeks, I will say. But if you do, it's very normal. It'll probably be like a period or less.

**Saskia:** Okay.

**SP:** Okay? And that's very normal. So I want you to wear pads for the first two weeks and not tampons.

**Saskia:** Mm-hmm (affirmative).

**SP:** And if at any point you begin to soak through four large sanitary towels within a two hour period. That is not normal. You must go straight down to the hospital.

**Saskia:** Okay. Mm-hmm (affirmative).

**SP:** Okay? It's not normal. If in the rare occasion you do go to the hospital, which is like I said it's very rare, they may need to do some investigations, blood transfusions, or even surgical

procedures to remedy whatever the issue is.

**Saskia:** Okay.

**SP:** Okay? That does include lifesaving surgery, where they perform a hysterectomy, they remove the womb.

**Saskia:** Okay. How often does that happen?

**SP:** I will get the exact figure for you now. I am going to send you this information off as well. The actual figure... Oh wait. I'm having to zoom in. Hysterectomy it's two women in a 100,000 women.

**Saskia:** Oh, okay. That's not so much then.

**SP:** No, it's very, very rare. But we have to tell every woman of every risk and the risk of death in a procedure like this is one woman in 100,000.

**Saskia:** Okay.

**SP:** It's very safe. Very, very safe.

**Saskia:** Okay.

**SP:** Okay?

**Saskia:** Mm-hmm (affirmative).

**SP:** Right. So what's going to happen now is you are going to receive an email from me with all the information. Okay? You will inside that package get pregnancy test and the pregnancy test is there for you to take three weeks later. So it tells you exactly when to take it. If the test is negative, the treatment is completed. Okay?

**Saskia:** Okay.

**SP:** Especially if you're feeling well, you're nauseous dies down, your period will come back a week or two later.

**Saskia:** Okay.

**SP:** If your period is... Sorry if the pregnancy test is positive, you need to ring up. Because it might just be that the hormones take a little while longer to come down, or it might be that you have some retained products left inside your vagina that may need some cleaning out. That again is very rare.

**Saskia:** Mm-hmm (affirmative).

**SP:** Okay?

**Saskia:** Okay.

**SP:** Do you have any questions with regards to the treatment or anything at all?

**Saskia:** So I think one question would be how soon, I mean, how soon after having an abortion in this way is it possible to get pregnant again?

**SP:** Well, what most women find is that they're more fertile than they were before because they now have been pregnant. Their body knows exactly what to do. So you need to be very careful because the first year after any pregnancy, you're more fertile than ever.

**Saskia:** Oh gosh. I didn't know that. That's... Okay.

**SP:** Yeah. The only time any of this can affect your fertility is if there is a major complication, which is extremely rare.

**Saskia:** Okay. Yeah.

**SP:** Extremely rare.

**Saskia:** Okay. You were explaining about the different tablets, it's probably not going to happen, but just in case it just happened, so with the first tablet, I take that by mouth. Right? And if I...

**SP:** You swallow that tablet, yes.

**Saskia:** So I swallow that. If I in the unlikely case that I feel sick and it comes out, do I still proceed with the other tablets? Or do I ring you or what do I do if I just...

**SP:** Give us a ring. Because normally if you vomit within the hour of taking the tablet, we can offer another one if you are close to a clinic.

**Saskia:** Okay.

**SP:** But it's all going to depend on when you vomit. So if it's after the hour, if you vomit after the hour, it makes no difference that tablet would have absorbed. Even if parts of it comes

out, the majority of that tablet would absorb and we would not be offering you another tablet.

**Saskia:** Okay. And then I would just go ahead with taking the other pills as you explained?

**SP:** You go ahead with the other ones. It's only in the rare occasion where a woman has taken a tablet and 20 minutes later she vomited that tablet up. We could make arrangements for you to collect another one.

**Saskia:** Okay.

**SP:** I mean, that's rare unless you're vomiting extremely often in the pregnancy.

**Saskia:** Okay. And yeah, that's very helpful, thank you.

**SP:** That's okay.

**Saskia:** And in terms of once the treatment is, well, if it goes through normally, which it probably will as you explained, are there any potential long-term effects of having this treatment or any risks or I've picked up, I've heard bits and pieces flying around about cancer possibly and stuff like that. You know how it is you pick up stuff and then it sort of without really having anything concrete in front of you, it's still placed in your mind. Is there any risk of that or?

**SP:** There is no evidence or any risks that I am aware of, of any link to any cancer.

**Saskia:** Okay.

**SP:** The only risk of abortion is number one, it fails and the pregnancy continues, but you would know that it would fail and then we have other options for you. We can do surgical procedures.

**Saskia:** Okay.

**SP:** Okay? Number two, that there was a major complication, which then causes you to need surgery or something like that. Okay? Which is very rare. The third thing is that should you have multiple abortions there is evidence to show that it can then affect miscarriage when you decide to become pregnant and continue a pregnancy. It can affect you being at a higher risk of miscarriage or premature delivery.

**Saskia:** Okay.

**SP:** But other than that, the cancer and things like that there is no evidence whatsoever.

**Saskia:** Sorry. That's just my alarm going off. Apologies. Okay. Yeah. That's very helpful. Thank you.

**SP:** That's okay. So keep a lookout now for my email that's going to be coming to you. You'll start to get some text messages about the delivery.

**Saskia:** Okay.

**SP:** I'm going to send you the step by step guide in that email. So please make sure you read the emails documents front to back before you start the tablets.

**Saskia:** Okay.

**SP:** Okay?

**Saskia:** Yup.

**SP:** Do you have any other questions?

**Saskia:** No, that's fine. Thank you. You've been very, very helpful and it all makes great sense. Yeah.

**SP:** Lovely. Okay. So yeah, just keep a lookout for your package and give us a ring if you need anything.

**Saskia:** Okay. Thank you so much for your help. I really appreciate it.

**SP:** That's all right.

**Saskia:** Thank you.

**SP:** You take care.

**Saskia:** Thank you.

**SP:** All right.

**Saskia:** Bye.

**SP:** Bye, bye.

# References

1. Department of Health & Social Care. Temporary approval of home use for both stages of early medical abortion. 2020.
2. Medical Abortion Up to 10 Weeks | BPAS, <https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/abortion-pill-up-to-10-weeks/> (accessed 2 October 2020).
3. Department of Health & Social Care. The Abortion Act 1967 - Approval of a Class of Places. 2019.
4. Department of Health & Social Care. Abortion Statistics, England and Wales: 2019. 2019.
5. NICE. Abortion Care (NG140). 2020. Epub ahead of print 2020. DOI: 10.1007/9781107338623.
6. Royal College of Obstetricians and Gynaecologists. Coronavirus (COVID-19) infection and abortion care. 2020.
7. NICE. Dysmenorrhoea | Topics A to Z | CKS | NICE, <https://cks.nice.org.uk/topics/dysmenorrhoea/> (accessed 2 October 2020).
8. NICE. Controlled drugs and drug dependence | Medicines guidance | BNF content published by NICE, <https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html> (accessed 2 October 2020).
9. NICE. CODEINE PHOSPHATE | Drug | BNF content published by NICE, <https://bnf.nice.org.uk/drug/codeine-phosphate.html> (accessed 2 October 2020).
10. HGEM | Home, <https://www.hgem.com/> (accessed 2 October 2020).
11. What Is a Secret Shopper | 4 Keys to Designing a Secret Shopper Strategy, <https://www.seelevelhx.com/healthcare-secret-shopper-strategy/> (accessed 2 October 2020).
12. Mystery shopper – invaluable patient perspective on ULHT wards and departments, <https://www.ulh.nhs.uk/news/mystery-shopper-invaluable-patient-perspective-on-ulht-wards-and-departments/> (accessed 2 October 2020).
13. Become a mystery shopper | BHR Hospitals, <https://www.bhrhospitals.nhs.uk/mystery-shoppers/> (accessed 2 October 2020).
14. Mystery Shopper Scheme, <https://www.pat.nhs.uk/get-involved/mystery-shopper.htm> (accessed 2 October 2020).
15. Moriarty H, McLeod D, Dowell A. Mystery shopping in health service evaluation. *Br J Gen Pract* 2003; 53: 942–946.
16. Friends Families and Travellers calls on government to address issues for Travellers registering at GP practices once and for all | Friends, Families and Travellers, <https://www.gypsy-traveller.org/news/friends-families-and-travellers-calls-on-government-to-address-issues-for-travellers-registering-at-gp-practices-once-and-for-all/> (accessed 2 October 2020).
17. Patient Registration: GP Surgeries: 7 May 2019: House of Commons debates - TheyWorkForYou, <https://www.theyworkforyou.com/debates/?id=2019-05-07a.423.5#g423.8> (accessed 2 October 2020).
18. King JJC, Das J, Kwan A, et al. How to do (or not to do) ... using the standardized patient method to measure clinical quality of care in LMIC health facilities. *Health Policy Plan* 2019; 34: 625–634.

# Christian Concern

Seeking justice, speaking truth,  
bringing hope.

[christianconcern.com](http://christianconcern.com) | [@CCConcern](https://twitter.com/CCConcern) | [facebook.com/ccfon](https://facebook.com/ccfon)

Christian Concern, 70 Wimpole Street, London W1G 8AX

'Christian Concern' is a trading name of CCFON Ltd. Company number 06628490.