Telemedicine for medical abortion in France: a difficult challenge

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A recent publication in this journal highlighted the lack of coordinated policy responses across Europe towards provision of abortion care during the current COVID-19 pandemic.[1] In April 2020, during the period of total confinement ('lockdown') decreed by the French government, exceptional legislation was introduced to facilitate the provision of medical abortion at home. Before COVID-19, medical abortion was authorised at home until 7 weeks of amenorrhea and approved providers were midwives and doctors (general practitioners and obstetricians/gynaecologists), working in private offices or in public abortion clinics. The new regulations that were introduced increased the gestational limit for medical abortion up to 9 weeks (63 days' amenorrhea) and also authorised telemedicine for consultations.[2] At the same time, a new system was introduced with community pharmacies whereby the abortion provider could send a prescription for the abortion medications (mifepristone and misoprostol) by email to a pharmacy chosen by the woman. The pharmacist could then dispense the drugs directly to the woman and the pharmacy was then reimbursed by Public Health Insurance. With the former (pre-COVID-19) model it was the provider who bought the drugs at the pharmacy and gave them directly to the woman during an in-person consultation. For that service, the provider was reimbursed at a fixed rate which corresponded to the cost of the drugs plus the fee for both pre- and post-consultations (total €183.57). In the new telemedicine model, providers only received the fee to cover the cost of the consultation (total €100).

A survey was carried out in June 2020 in the Ile de France region (Paris and seven surrounding departments, representing nearly 20% of the French population) among independent midwifery and medical staff that perform medical abortions (personal communication, 2021). Fifty providers responded to the survey. Only half the respondents stated that they were offering a telemedicine consultation. Furthermore, only one individual (a doctor) performed medical abortions exclusively by teleconsultation. All the other respondents still had at least one in-person consultation with the woman. When a consultation was performed by telemedicine, it was usually for post-abortion follow-up purposes (77% of cases). When the respondents were asked if they would continue to use telemedicine for medical abortion after the end of the lockdown only 52% of the providers responded positively.

Several possible explanations that need further exploration can be given in order to understand the reluctance of French doctors and midwives to use telemedicine for medical abortion during COVID-19. First, the organisation of care in France is such that abortion providers are often working as individual practitioners and so perhaps feel less well supported to embark on new practices, unlike those providers in settings such as the UK where abortion care is delivered from large healthcare structures and following national guidance.[3] Second, the health authorities in France did not sufficiently advertise this telemedicine option to either women or health professionals, leading to ignorance and ultimately to few requests or offers to deliver this model of care. Confusion around policy and lack of support from professional organisations have also been described among doctors in Quebec as key barriers to adoption of innovative practices in abortion care.[4]

In addition, practitioners may adhere to the belief that it is imperative to see someone seeking abortion in person as they are highly likely to be vulnerable, or a victim of violence or reproductive coercion. Providers are also nervous about gestational age determination based on last menstrual period alone rather than a pre-abortion ultrasound. In France,

providers have even been reluctant to replace a post-abortion ultrasound or a quantitative serum human chorionic gonadotrophin measurement with a self-performed, low-sensitivity urinary pregnancy test, so performing a medical abortion with a 'no-test' protocol therefore might seem a step too far. The fear of not diagnosing an ectopic pregnancy before abortion or of missing an ongoing pregnancy after abortion is very present among providers, as is the fear of litigation against the individual practitioner that could follow such scenarios. Some doctors still believe in the essential value of a clinical examination. For example, many gynaecologists still perform routine vaginal examinations as part of regular antenatal care for monitoring the progress of a (continuing) pregnancy. Telemedicine, by removing the opportunity to undertake an 'essential' clinical examination, therefore may be viewed as not following best clinical practice. Qualitative research among French abortion care providers is therefore required to better understand the barriers and facilitators to adoption of telemedicine for medical abortion care.

Studies on the safety, effectiveness and acceptability of telemedicine medical abortion at home during COVID-19, from Scotland and England and Wales, published in this and other journals, provide much support for this model of care.[5 6] However, the impact of these publications on abortion service delivery in a setting such as France with a different healthcare system may be less. Also, as with any publication in English, it is less likely to be read by providers for whom English is not their first language, in the first place. And, of course, anything new coming from the "Perfidious Albion" at the current time might be viewed with suspicion! What is needed, therefore, is for large studies to be conducted in France as soon as possible on telemedicine for medical abortion at home. It will be essential that the results are published in French and disseminated widely throughout the French-speaking countries. This, in my opinion, is the best way to persuade providers to use telemedicine for medical abortion and to facilitate access to abortion in France.

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