

BULLETIN BOARD

LETTERS

What constitutes 'unprotected sex'?

Madam

Every day we experience clinical scenarios that make us question our practice. However, until recently, I have never questioned the definition of 'unprotected sex'.

A 15-year-old attended a local clinic for emergency hormonal contraception (EHC). She was Day 27 of her cycle at presentation and had had sex with withdrawal on five occasions during the month. However 19 hours earlier, on Day 26, she had had definite intravaginal penetration and ejaculation. She was most explicit with her history and clearly the most recent sexual encounter had been a very different experience from the other five episodes. She was, however, refused EHC on the grounds that she had had 'unprotected sex' more than 72 hours earlier in the cycle.

My own view differs from this. I believe that withdrawal is indeed a form of contraception, albeit not a particularly good one, and that this is not a reason to withhold EHC. Indeed, many countries in the world use withdrawal as a prime method of contraception. Failure rates per 100 women years¹ for coitus interruptus are quoted as 6–17, and do not differ markedly from male condom (2–15), female condom (5–15), or even Persona (6). If we will not accept withdrawal as sex having been protected then, by rights, we should not accept less than optimal condom use or Persona used correctly but 'jumped the red light' yesterday.

Nowadays, nurses are able to issue EHC under patient group directives (PGDs). They must stick rigidly to these guidelines. PGDs stipulate that EHC is contraindicated if 'unprotected sex' took place more than 72 hours earlier. PGDs differ, but I have not seen one that goes on to clarify what is meant by 'unprotected sex'. What directives should we give nurses when 'unprotected sex' has indeed occurred earlier in the cycle? To some extent all sex is unprotected, since no contraception is 100% effective even Implanon (sadly) has been associated with a few pregnancies.

We also see women attending clinics after sex, having practised withdrawal, who request emergency contraception. I suspect that if penetrative intercourse took place, or ejaculation occurred on or near the genitalia, then EHC would be given. Perhaps these patients are attending because they have reason to doubt that ejaculation took place safely.

Since the safety of Levonelle is undisputed, we can argue it is virtually always better to give EHC than withhold it. This is not the same as having the confidence to fit a postcoital intrauterine device (IUD).

Perhaps the term 'unprotected sex' needs careful definition or even legal clarification, for all of us working daily with this common, but if you think about it, rather confusing clinical expression. A suggested definition might be 'penetrative vaginal intercourse in which either less effective contraceptive methods (withdrawal, condoms male/female, or natural

methods) has not been used optimally, or no method used at all'.

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Reference

- 1 Guillebaud J. *Contraception: your questions answered* (3rd edn). London: Churchill Livingstone, 1999; 14.

Need for alarm calls

Madam

I write to remind journal readers of the need for panic alarms in family planning clinics (FPCs). An incident occurred at Rhyl FPC on 27 September 2002 when a lady attended for routine fitting of an intrauterine device (IUD). All went well until the end of the procedure when the lady began to have a tonic-clonic seizure and was incontinent of urine. The attending doctor and nurse were able to stop her falling onto the floor but, because nobody was able to hear their cries for help, they were unable to summon assistance. Fortunately the fit soon ended, and the lady recovered completely within the space of a few minutes.

Although there was more noise than usual because of alterations being made to the building at the time, the need for panic alarms was highlighted. Subsequent discussion revolved around whether to fit call buttons on the wall (and, if so, precisely where) or whether staff should be advised to carry personal alarms when carrying out procedures in examination rooms. It was pointed out that the latter would be considerably cheaper as well as allowing much more flexibility in the use of rooms. While building work is completed it is likely that the policy of the Conwy and Denbighshire NHS Trust will be that staff carry panic alarms during IUD fitting at all 22 of their FPCs.

The incident also serves as a reminder that IUD fitting should always be carried out with at least two people in attendance.

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Counselling, psychological morbidity and termination of pregnancy

Madam

In their editorial, Hodson and Seber¹ suggest that undergoing a termination raises psychological issues that are 'multiple and profound', 'often' leading to 'resentment, anger and sadness'. The editorial assumes that opting to have an abortion has 'immense consequences' for all women making such a choice, leading 'many' to 'mourn' the lost possibilities. Available evidence strongly contradicts their impression.^{2–5}

In the past our practice referred women seeking an abortion for counselling prior to the procedure. This introduced a 2–3 week wait that was unacceptable. A small number of our medical and nursing staff now offer women a chance to discuss their choices regarding the method, the risks and possible consequences (including psychological) and future

contraception. Out of 50–70 patients a year over a 5-year period, we have referred only two women for more in-depth counselling. Anecdotally, we find the most commonly expressed emotion after abortion is relief. We also encounter gratitude, probably because women do not expect find a speedy and non-judgemental service.

We found that the change in our service led to a significant drop in gestation at procedure and an increase in the number of women choosing a medical termination the preferred choice for many women.⁶ We also found an improved attendance at contraceptive follow-up. There is evidence that pre-abortion discussion combined with immediate post-abortion provision of contraception may significantly increase contraceptive use at 6 months post-procedure.⁷

Hodson and Seber are premature to advocate a 'right' to counselling to protect from morbidity that prospective studies suggest is rarely associated with abortion. There are many questions to be answered. Does pre-termination counselling (as opposed to a discussion with an appropriately trained health professional about choices, methods, risks and contraception) protect women from post-abortion psychological problems? What proportion of women would choose to have counselling, and are they the ones at risk of adverse psychological sequelae? If counselling is protective, ways of predicting which women are at greatest risk of psychological morbidity need to be explored, as discussed by Butler.⁸ Also, can a counselling service be structured in a way that avoids adding significant delay for some women?

We believe that selected individuals in general practice are ideally placed (given time, training and resources) to effectively discuss choices with women who have an unintended pregnancy. Further research might help develop forms of risk assessment to identify those women who warrant 'professional' counselling.

In conclusion, we feel Hodson and Seber's article is written with an inappropriately pessimistic view of how abortion affects a woman psychologically. We would argue that more research is needed before a blanket 'right' to counselling is advocated.

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