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 (2–5), female condom (5–15), or even less effective contraceptive methods you think about it, rather confusing clinical care. A careful definition or even legal clarification, for having the confidence to fit a postcoital EHC than withhold it. This is not the same as attending because they have reason to doubt that penetrative intercourse took place, or ejaculation was, however, refused EHC on the grounds that she had had ‘unprotected sex’ more than 72 hours earlier in the cycle.

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 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 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 can carry 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. Annually, we find that 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 make sex 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 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 inappropriate 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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References