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 use (2–5), female condom (5–15), or even Persona (6). If we will not accept withdrawal as having been protected then, by rights, we must stick rigidly to these guidelines. PGDs stipulate that EHC is contraindicated if 2–5 contraceptive use at 6 months post-procedure.

We also see women attending clinics after unprotected, since no contraception is 100% effective. To avoid asking what is meant by ‘unprotected sex’, we should consider: what were the circumstances of the sex act, and how likely was it to result in pregnancy? We also need to consider the physical and emotional consequences of our refusal to give EHC to patients who 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 contraceptive). Out of 50–70 patients a year over a 5-year period, we have referred only two women for more in-depth counselling. Alternatively, we find many women 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.5 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.

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 offer any protection to a discussion with an appropriately trained health professional about choices, methods, risks and contraception? Does 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, what are the risks and possible consequences? We welcome the opportunity to discuss these issues.

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 appropriately 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.

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 with preabortion contraception counselling. We 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 references for counselling is protective, what are the risks and possible consequences? We welcome the opportunity to discuss these issues.

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 appropriately 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.