More on contraception

I read the letter by Dr. Patricia Lee June in the June AAP News (p. 272) with great interest. I have made the same argument many times with those who propose that post-coital contraception does not end pregnancies, but, on the contrary, only prevents them. They are correct that this form of contraception often prevents conception. On the other hand, this form of contraception also prevents implantation of an already conceived future child. In fact, this form of contraception may also cause the loss of a very recently implanted future child.

Our mantra that children are not just little adults is true. Just as children grow to become adults, zygotes grow to become children if only we give them a living “home,” nutrition and a chance. In this case, it does not take a village; it takes a mom. We, the village, should support moms through education, legislation and assuring at least paternal economic support. We should continue educational efforts to preferably postpone sexual activity among our adolescents.

Realistically, this education should include safer sex and conception prevention discussions. It should be emphasized that the only 100% effective way to prevent pregnancy and STDs is abstinence.

The issue Dr. June raises regarding changing definitions is one I have written about as well. This type of word play has occurred throughout the ages and has led directly or indirectly to practically all large-scale genocides on record. It has been used to rationalize slavery and the disenfranchisement of various factions of people throughout history. I do not know why we should be so surprised that it would be used here as well.

Is this all semantics? I do not believe so and neither did the woman I consensualy who accepted post-coital “contraception” after being raped only after her physician told her it would prevent fertilization but not end a pregnancy. Her beliefs were that human life begins at conception: a completely logical and scientific conclusion.

She went on to tell me that her greatest psychological trauma was not the rape but the fact that she will never know if she inadvertently induced an “abortion,” something she would not have knowingly done.

After reviewing the literature and discussing this topic with many women, I came to the conclusion that providing post-coital contraception should require informed consent. In this vein, as a member of a national sexual assault guidelines committee coordinated by the American College of Emergency Physicians to provide guidelines on the management of sexual assault, I (and others) adapted an information sheet to ensure that this could occur (p. 129-130, “Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient,” http://acep.org/library/index.cfm?id/2101.pdf). We tried to remove the confusing word salad and just be clear about what we know and do not know about post-coital “contraception.”

Prominent members of multiple organizations including the American College of Obstetricians and Gynecologists, the Academy, American College of Emergency Physicians, the national SANE (Sexual Assault Nurse Examiner) program and others were involved in the production of these guidelines, and I hope that your readers will obtain a copy not only to potentially improve their management of sexual assault cases, but also to implement the formal provision of informed consent for post-coital contraception. It is not the provider’s belief that is paramount, but those of the women we are serving. Shouldn’t we provide them the most accurate information available? How will this occur if these medications are over-the-counter? Do the pharmacists have time to go through this information with each consumer? What role does the provider and pharmacist’s moral code play?

Randy Cordle, M.D., FACEP, FAAP
Boise, Idaho