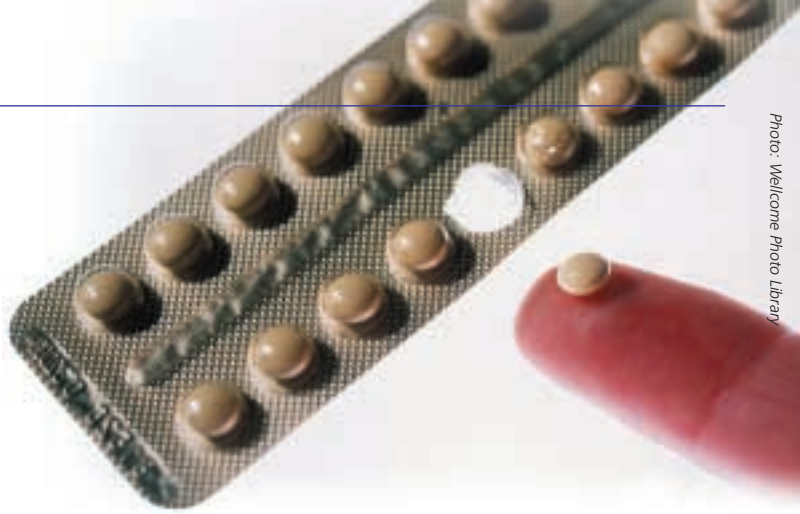
Medical facts and biblical principles should shape prescribing argues **James Tomlinson**

Conscientious contraception



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A recent House of Commons inquiry declared the nation's sexual health to be in increasing crisis.[1] The committee made a number of recommendations: sex and relationship education as a core part of the national curriculum; prioritisation of contraceptive services; increased open access for terminations; performance management of primary care trusts against sexual health standards.[2]

General practitioners are on the frontline of a government strategy on sexual health that has 'safe sex' advice and the provision of contraception - including the Morning After Pill (MAP) - at its heart.[3] Under the new GP contract, practices will receive quality payments for having a policy on the provision of emergency contraception that ensures delivery.[4] However, Paul exhorted Christians not to conform to the pattern of this world but to be transformed by the renewing of our minds.[5]

I am on an ongoing journey: integrating my faith and practice in the area of contraception and sexual health. I remain convinced that (from both biological and biblical perspectives) the human embryo should be considered a human being from fertilisation.[6,7,8] Quoting John Wyatt, 'If we recognise a deep uncertainty and ambiguity about the moral significance of the embryo or early foetus, we have to ask: "What is an authentically Christian response to this deep ontological uncertainty?" Surely an appropriate response is to vote in favour of protection and against intentional destruction.'[9]

Accordingly, I avoid prescribing any contraceptive that may act after fertilisation. However, obtaining and assessing relevant information on the mechanisms by which contraceptives act is difficult. I have been guided by Professor of Family Planning John Guillebaud's recent review of methods he considers to act before fertilisation: combined oral contraceptive pill (COCP), *Cerazette* - a new progesterone only pill (POP), *Implanon*, *Depo-Provera* plus barrier methods.[10] His conclusion that these hormonal methods operate prior to fertilisation is on the basis that they *effectively* prevent ovulation as well as act on the cervico-uterine mucus to reduce sperm-penetrability and therefore block sperm migration. He supports the use of *Cerazette*: 'It is as effective as the COCP at blocking ovulation'. However, a recent review of *Cerazette* (desogestrel 75mcg) by the *Drugs and Therapeutics Bulletin* concluded only that it inhibits ovulation more frequently than a standard POP, since there aren't any published trials comparing *Cerazette* and COCPs.[11] In a double blind trial comparing desogestrel and levonorgestrel, ovulation occurred in 1.7% of desogestrel cycles compared to 28% of levonorgestrel cycles. (Ovulation was assessed by ultrasound and serum progesterone concentration.) Given that *Cerazette* acts both to block ovulation and thicken the cervico-uterine mucus, Professor Guillebaud's assessment that it does not act post-fertilisation seems valid on current understanding.[12]

As I feel that they may act after fertilisation, I will not prescribe (first-time or repeat) the MAP, POPs (except *Cerazette*) or intrauterine contraceptive devices (including *Mirena*).[13,14,15] Even in a patient-centred consultation, where treatment options are shared and the patient chooses her treatment, I am still responsible for what I sign. To prescribe a contraceptive that works after fertilisation is to participate in the potential destruction of human life.

I have sought a management pathway that shows compassion and respect for my patients whilst not compromising my convictions. If my beliefs may affect the advice or treatment I provide, I should explain this to my patients, telling them of their right to see another doctor.[16] When patients request contraception, I discuss how the different contraceptives work. I explain that some people believe that life begins at fertilisation and explore their thoughts about this. If they choose a method that acts after fertilisation, I explain that, due to when I believe life begins, I will not prescribe this for them but can refer them to another doctor. If they are already on a POP other than *Cerazette* and have attended for medication review, I check they understand the implications of its mechanism of action and discuss whether they wish to continue it. I have found that a number of my patients will only accept contraception that acts pre-fertilisation.

Reassessing my approach to contraception is painful and challenging. Reading relevant articles, attending conferences (such as 'Turning the Tide' and 'Handling Ethical Conflicts in the Consultation') and talking to Christian colleagues have all helped.[17] Compromise lies in pragmatically prescribing all contraceptives regardless of their mode of action. I choose to practise what I believe about the status of the embryo whilst continuing to engage with patients caught in society's sexual crisis.

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