
**Peter May** and **Ruth Selwood** explain their contrasting positions.

# Should we prescribe contrace

## 'Yes!' **Peter May** is a GP in Southampton

There are those - mainly girls in their mid-teens - who come for contraceptive advice before embarking on a sexual relationship. If she has not been prescribed contraception *before*, I ask about her intentions. Mostly, she has made her mind up already. Sometimes mothers attend along with their daughters, wanting them 'fixed up' before they start having intercourse.

Early in my career, I thought naively that I could persuade a young woman to change her mind: she returned within a few weeks requesting a termination. Now, when my advice is called for, I ask my patient to listen very carefully: 'I will say this only once!' If after due reflection, she still wants to embark on a sexual relationship, and comes back to me for contraception, I tell her that I will prescribe it without further discussion unless she initiates it. More often, these young women then go to a Youth Advisory Clinic instead and probably change to a GP with whom they feel more comfortable! The doctor-patient relationship is easily destroyed.

With gentle irony, I point out that there is a close, scientifically proven, correlation between intercourse and having babies. Of course, I warn of the risks of diverse infections. I point out the emotional dangers of multiple relationships, which statistically decrease the likelihood of entering into an enduring relationship in the future. I even talk about the wonderful joy and confidence that can be experienced in a unique relationship. Sex is fun from the beginning because you don't bring memories or hang ups into the relationship; it remains fun in the future because of the deep trust in each other's faithfulness.

It would be impertinent of me to discuss my faith unless it came up naturally in conversation: they have come to me for contraception not conversion. These discussions are always a challenge, especially when mother is present, as big questions can be raised about mother's values, lifestyle and the example she has set her daughter.

However, 99 percent of these young women have already begun a sexual relationship, so providing them with contraception is hardly facilitating their sin. My task is one of damage limitation. If they become pregnant, there is a very high risk they will have the pregnancy terminated. I would sooner that life was not created than that it should be destroyed. I am not greatly enamoured by the idea that they should get herpes, warts, chlamydia, cervical carcinoma or something even worse! Therefore, I teach them about these risks and encourage them to use condoms, which I provide if asked.

If I was to take the moral high ground and wash my hands of their iniquities, I guess I would not stop there. I wouldn't be able to give safe-sex advice to homosexuals. I would be tempted not to prescribe for anyone with a self-inflicted illness. Woe betide smokers with ischaemic heart disease: 'Buy your own aspirin and nitrate sprays!' I'd have to give short shrift to alcoholics with high blood pressure. Insomniacs with troubled consciences would remain tired: 'Do you expect me to give you a drug-induced peace, when you have no peace?' Obese people wanting Orlistat: 'Just eat less!' An injured hang-glider requesting analgesia: 'What! If God wanted you to fly, he'd have given you wings!' Such an approach would shift an intolerable workload onto my long-suffering partners!

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No, it's a messy old world. People can behave appallingly but we are called to follow one who rolled up his sleeves and got alongside them. Jesus didn't come to condemn the world but to save it;[1] that judgement was God's business, not ours.[2] As guilty sinners who have found God's forgiveness, we should not be overly preoccupied with own moral purity. Jesus told the story of the religious priest who walked by on the other side, while a wretched Samaritan outcast rushed to a poor man's aid.[3] Much misunderstood, Jesus became the friend of sinners.[4] He helped without bullying them or overriding their decisions.[5] Such was his identification with lost people that he became sin for us and hanged on a gallows for our redemption.[6]


**REFERENCES**

1. John 3:17
2. Matthew 7:1-5
3. Luke 10:29-37
4. Matthew 11:19
5. Matthew 19:21-24
6. 2 Corinthians 5:21; Galatians 3:13


# eption for unmarried patients?

## 'No!' **Ruth Selwood**, former CMF staffworker, is a GP registrar in Birmingham

This controversial subject has been previously aired in CMF.[1] I fear we are kidding ourselves that extramarital intercourse with contraception is preferable to unwanted pregnancies with abortions.

Socially, the price of sex used to be life-long union with children, social and financial responsibilities; now it is free on prescription. Disintegration of the marital unit is the destruction of society itself. Divorce is more likely after extra-marital sex; cohabiting couples are more likely to split up. The illegitimacy rate has soared from five to over 30 percent since contraception was introduced. Fragmentation of homes can only perpetuate, as children grow up imitating their parents.

Physically, harm-reduction is mythical.[2] Despite sex-education programmes and free contraception, risk displacement is causing soaring teenage pregnancy and STD rates, whilst age at first intercourse keeps falling.[3]

Psychologically, contraception doesn't protect against emotional damage associated with multiple partners. Outside of a life-long trusting relationship, sex is a lie. Sexual body language communicates, 'I give you my all'; failure to set it inside a life-long commitment reveals, 'I am holding back'. I often use the illustration of gluing two pieces of paper together and then ripping them apart: little bits remain stuck to each other.

Spiritually, fornication is sin. We should neither impose our morality nor facilitate sin. Whilst not expecting them to conform to our standards, God's blueprint is still in our patients' best interests. It is illogical to argue that we should provide protection as they will have sex anyway. By providing the means, we heighten the motive, opportunity and exposure to the consequences. Suggesting, 'Shall we do evil that good may come?'[4] is unbiblical. I cannot imagine the Lord dishing out contraceptives to unmarried women. Jesus was non-judgemental yet uncompromising with the woman caught in adultery: 'Neither do I condemn you. But go, now leave your life of sin'.[5]

When a woman requests contraception for the first time, I certainly try to dissuade her. I explore issues of self-esteem, coercion and whether she feels this is Mr Right. I discuss STDs, unplanned pregnancy and emotional damage. I explain I am unable to prescribe for her, as I don't feel it is in her best interests. I offer her the option of seeing another doctor, apologise if this creates difficulties and explain that I would be delighted to see her in the future.

I saw this approach working effectively as a gynaecology SHO. Following a termination, my registrar told a 14 year old girl that it was vital she take the pill in future. As she neglected the wider issues, I returned (with her permission) to discuss with the girl

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whether she had wanted sexual involvement, her feelings about the consequences, self-esteem and sex as communication. It emerged she had felt coerced into sex, was shocked by the consequences and didn't wish to have sex again. She was happy to go home and discuss everything with her mother.

The hardened pill user is trickier. I ask whether she is in a relationship. If it's a casual affair, I discuss the physical and emotional risks of sex; if he's Mr Right, I discuss the greater likelihood of break-ups in cohabitating relationships. I then get my GP trainer to sign the prescription; although arguably, in so doing I may be leading a Christian brother to sin.

Believing that life begins at fertilisation, I also have reservations about contraceptive mechanisms of action. Many contraceptives act by preventing implantation and so are in reality 'abortifacient'.[6] Regardless of patients' marital status, I prescribe only methods guaranteed to inhibit ovulation - a subject of current debate (see my letter in this issue).[7]

Taking this line is not easy. My heart sinks in pill-request consultations. I fear losing popularity or appearing off the wall. Since I can't offer a full range of contraceptive services, I try not to prejudice the options I discuss with patients. I decided against placing a notice in reception saying I don't see pill requests: I value discussing patients' sexual lifestyles with them. I strive not to appear moralistic, but rather compassionate for my patients, desiring to save them from harm.

### REFERENCES


1. Gurney R. Contraception for the Unmarried? *JCMF* 1995; July:8-11
2. Richards C. Sleeping with the Enemy. *Triple Helix* 2003; Autumn:11-13
3. Stammers T. The condom controversy - safe sex or Russian roulette? *Triple Helix* 2002; Summer:10-11
4. Romans 3:8
5. John 8:11
6. Gardner G. Letter - poistcoital contraception. *Triple Helix* 2000: Winter:20
7. Selwood R. Letter - when do contraceptives work? *Triple Helix* 2003; Winter:page 20


What position do you take? Is there a particular issue that you would like featured in Head2Head?

Write in to **rachael.pickering@cmf.org.uk** and join in the debate. In the next issue, we will publish correspondence along with the next Head2Head.