Emergency Contraception: How it Works and the Ethical Issues

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Introduction

Since 1998, women living in the United States have been able to obtain emergency contraception from a pharmacist’s through a written prescription. In February 2001, a petition was made to the United States Food and Drug Administration (FDA) by the Center for Reproductive Rights to allow emergency contraception to be sold over the counter. The FDA denied the petition for emergency contraception over the counter sales in May of 2004 (Weismiller, 2004).

On August 24, 2006, following many years of heated debate, the FDA approved Plan B, also known as “the morning after pill”, to be sold over the counter. This recent approval allows women 18 years of age and older to purchase “the morning after pill,” at their local drug store. The FDA has chosen to continue prescription only access for those under the age of 17 (FDA, 2006).

The purpose of this paper is to outline how the “morning after pill” works and the ethical issues related to it. This is an important subject that nurses should become more knowledgeable about so they may educate a patient or understand how their own values and beliefs may be affected.

Review of Literature

Common reasons for emergency contraception include failure of a barrier method or some other form of contraceptive during intercourse or lack of any method of contraception at all. Additional uses include women who have been sexually assaulted, to be sure they will not become pregnant (Weismiller, 2004).
The treatment (known as Plan B) where the woman has a routine contraceptive method before turning to emergency contraception consists of two oral tablets containing 0.75 mg of levonorgestrel each. This is ten times greater than the dose found in certain oral contraceptives (Weismiller, 2004). No single method of action has been identified for Plan B. One theory is that levonorgestrel has an impact on ovulation by suppressing or delaying the luteinizing hormone, as well as inhibiting follicle rupture (Conrad & Gold, 2004). This is thought to be the predominant mechanism of action of the emergency contraceptive. Other modes of action include endometrial wall changes which affects implantation even if fertilization has taken place. An existing zygote previously implanted into the wall of the uterus prior to taking “the morning after pill” will not be aborted or terminated (Schorn, 2006).

Timing is key when using an emergency contraception method. Success is highest if used with in the first 72 hours post-coitus but may be effective up to 5 days after intercourse (Shorn, 2006). In 2004, Weismiller noted, “a recent multicenter, randomized controlled study found that the sooner the first dose was taken after intercourse, the greater the effectiveness” (p. 709). He also mentions that if used within three days (72 hours), it fails only 4% of the time but when delayed to five days then failure of the method can increase to as high as 10%.

Adverse effects that accompany use of the “morning after pill” include nausea (occurring in almost half of those who use the emergency contraceptive), vomiting, dizziness, and fatigue. There is limited data on teratogenic effects because few studies have been conducted to investigate the effects of emergency contraceptives on a fetus or after birth. The only contraindications to the use of the “morning after pill” are known hypersensitivity, undiagnosed genital bleeding, or suspicion of pregnancy (Weismiller, 2004).
Prior to the legalization of over the counter use there was debate about advance provision. Advance provision is giving a prescription of the emergency contraceptive to a female in case the situation would arise where a routine contraception was not used or failed. (Raine, Harper, Leon & Darney (2000) found that by providing a prescription in advance the “morning after pill” was used three times more often when compared to providing education about emergency contraception alone.

While physicians providing advance prescriptions may help stop unwanted pregnancies, health care providers play a vital role in education of patients, especially when providing an advance prescription that increases the use of emergency contraception. Weismiller (2004) stated that, “although emergency contraception can reduce the risks of pregnancy it is less effective than consistent use of methods intended specifically for routine contraception” (p. 710).

The risk of promiscuous behavior increasing because of the new more accessible ways of getting the “morning after pill” over the counter is an issue often discussed. Prior to over the counter approval, physicians were skeptical about providing a prescription of emergency contraception, fearing that it would cause an increase in risky behaviors (Litt, 2005). If this is the case, than providing it over the counter there could contribute to the increased risk for the spread of HIV and other sexually transmitted diseases. It is imperative that health care providers issuing emergency contraceptive make sure that their patients are aware that emergency contraception does not protect them or their partner against HIV or any other sexually transmitted diseases (Schorn, 2006).

The ethical issue here is nurses’ rights and responsibilities in the administration of emergency contraception. Jacobson (2005) addressed a story regarding a nurse who said that she would refuse to administer emergency contraception on the basis that she thought “it would be
morally wrong for her to dispense it” during an interview (p. 27). The story further details that
she was not hired at the hospital but that another nurse who said that she would administer the
emergency contraceptive was hired. Needless to say the nurse who did not get hired sued the
hospital on many basis including “emotional anguish”.

A nurse by the name of Linda Bell stuck up for her in saying that, “There are things
happening every second when that egg and that sperm unite. That is life” (Jacobson, 2005, p.
27). Linda Bell and many other nurses chose to resign from their positions in protest of a
protocol that was going to require them to tell all patients about emergency contraception
options. Jacobson further stated that although nurses have rights that should be protected, the
nurses role is to protect the rights of patients, which would include offering them medical
treatment they are entitled to have and the knowledge they need to make decisions. Some say
that nurses need to give the care that they have been trained to give and not abandon the patient
(Jacobson, 2005). The ANA (2001) Code of Ethics for Nurses agrees with this, however,
provision five also states that “the nurse owes the same duty to self as to others.” The presence
of these two conflicting expectations demands active organizational discussion of all parties roles
prior to placing nurses in this delicate dilemma.

Conclusion

Emergency contraception is a back up method for failed or unused contraception prior to
or during sexual intercourse and has been recently approved by the FDA for over the counter
sale. Plan B does not interrupt an already fertilized and implanted egg, and therefore is not an
abortive method. Using emergency contraception in a timely manner, preferably before 72
hours, increases its effectiveness. There are few side effects that come with the use of emergency
contraception, the most predominant being nausea. There are many ethical issues that stem from
the use of emergency contraception these include the increased risk of HIV and STD’s as well as nursing roles and responsibilities in administration and the effects of their moral beliefs.

Nursing implications for practice include that if a nurse so chooses to work in the environment where they are in contact with emergency contraception administration they need to be sure to state their moral beliefs to the employer and find out if their state has laws that protect their rights to those beliefs during practice. When a nurse chooses to administer an emergency contraception it is crucial to provide full information about the drug to the patient. As Schorn (2006) concluded that emergency contraception does not protect against HIV and other STD’s.

Prior to researching emergency contraception I thought that Plan B was “considered” a form of abortion which I actually was confusing with RU-486 (not sold over the counter). Although I still question if it could be in some way a form of abortion if it can stop a fertilized egg from being implanted into the uterine wall, disrupting the pregnancy post conception. I did not know how emergency contraception worked and now I do. I am also more informed on the FDA’s process in its recent over the counter approval. All in all I am a little bit on the fence regarding the matter. I want to say I do not agree with it, but I can hardly say that when I approve of birth control pill use as routine contraceptive. What I do know is that it needs to be used in a responsible and reasonable manner, just as it is stated, Plan B, meaning that the user has a routine contraceptive method before turning to emergency contraception.
References


