

RHETORIC

Editor's Note

In her persuasive essay, "Plan B for America," Amelia Wing offers a carefully researched, formal argument. Notice how the essay's thesis is revealed gradually, in three steps. What rhetorical purpose does this technique serve? Is it effective? Wing's discussion offers explicit connections to the essay's thesis in every body paragraph—without restating the thesis. Her argument is primarily logos based in the body: the essay's approach to the topic is clinical and objective. She leaves herself out of the discussion by not developing her ethos and maintains an impersonal tone throughout. What sort of audience would respond positively to this approach? Do you find evidence of pathos or ethos elsewhere in the essay? The conclusion invokes historical context: is the analogy fair and appropriate? What audience is targeted via this technique?

Plan B for America

Amelia Wing

Approximately eight out of every one hundred girls between the ages of fifteen and nineteen will become pregnant each year—the equivalent of 130 out of the 1600 girls in the class of 2010 at Cal Poly (Ventura). The United States currently claims the highest teen pregnancy rate of the industrialized world, resulting in many unnecessary teen pregnancies and abortions each year. Often young mothers cannot afford the time and money required to support a child and must drop out of high school; some even go on to become welfare recipients at the expense of our nation's taxpayers. To change this unfortunate chain of events, we must halt the cycle before it begins: prior to conception. One solution to this massive problem manifests itself in the small and simple form of the emergency contraceptive pill appropriately named Plan B, which has the potential to prevent innumerable unplanned and unwanted pregnancies before it becomes too late.

Plan B, an FDA-approved emergency contraceptive pill, reduces pregnancy by 75–89% if taken within 72 hours of unprotected sex (Planned Parenthood of Santa Barbara 1). Also known as the morning-after pill, Plan B is NOT an abortion pill and will have no effect on an existing pregnancy. It merely contains a large dose of the hormone progestin, also found in birth control pills, and works to "prevent pregnancy by stopping ovulation and fertilization" (Planned Parenthood Federation of America, Inc.). According to Planned Parenthood, Plan B "could prevent 1.7 million unintended pregnancies and 800,000 abortions each year in the United States" (Planned Parenthood Federation). Plan B offers teen girls a simple, safe, and effective alternative to unwanted pregnancy and abortion.

RHETORIC

Recognizing Plan B's capacity to prevent millions of unwanted pregnancies, the Food and Drug Administration approved Plan B on August 24, 2006 as an over-the-counter drug for women age eighteen and older after several years of controversy surrounding the decision. Barr Pharmaceuticals, the manufacturer of Plan B, originally applied for the drug's over-the-counter status in 2003, which has been available in the United States by prescription since 1999 (Davidoff 20). In FDA committee hearings on the case, members voted "twenty-seven to one that consumers could properly use Plan B as recommended on the proposed labeling and judged from the actual use study" and "twenty-seven to one that the actual use study data were generalizable to the overall population, including adolescents" (Davidoff 20). Yet, the FDA rejected the proposal for over-the-counter status citing concerns on adolescent use, a decision viewed by many as more political than scientific. Out of this rejection arose a compromise: those eighteen and over can purchase Plan B without a prescription, while those seventeen and under are required to obtain one. Dual status provides an enormous opportunity to prevent pregnancies for those over the age of eighteen by making Plan B more accessible, while at the same time leaves an entire sexually active demographic of users—adolescents—in the dark. Plan B should be sold over-the-counter without age restrictions due to its enormous potential to reduce teen pregnancy in America.

By requiring a prescription for minors, we limit the ability of Plan B to prevent pregnancies. Plan B's effectiveness depends heavily on time and its chances at preventing pregnancy decrease with each passing day. Providing women with easier access to Plan B during hours that a prescription may not be obtainable constituted a major argument for switching Plan B from prescription-only to over-the-counter status. Unprotected sex can easily happen outside of regular business hours regardless of age. By restricting the times during which any age group can obtain Plan B, we restrict Plan B's ability to make a difference.

Requiring an ID to enforce the current age restrictions for over-the-counter medicine, Plan B, impedes its goal of reducing pregnancy by discouraging the use by teens as well as other demographics. Women over the age of eighteen might feel embarrassed about approaching a pharmacist and showing identification, thereby identifying themselves as having a need for emergency contraception. Storing Plan B behind the counter at pharmacies and requiring an ID could cause, "a serious and humiliating invasion of privacy that would intimidate many women and prevent them from obtaining the drug," therefore affecting access for those eighteen and over as well (Davidoff 22). In addition, the dual status compromise bars women without valid government IDs from obtaining Plan B, creating discrimination against aliens or illegal immigrants in our country and compromising their health. Teens, however, face more than embarrassment or lack of identification: age restrictions challenge minors to first obtain a prescription written by a doctor. Doctor's appointments often need to be sched-

RHETORIC

uled weeks or months in advance, making it no easy task for a teen to secure a pill considered most effective if taken within twenty-four hours.

Although most agree that age restrictions make it unnecessarily difficult for teens to obtain Plan B in a timely manner, a major concern in the debate includes its safeness and effectiveness in teen girls. Actual use studies in the original FDA committee hearings demonstrated that teens used the drug as correctly as adult women. In addition, a study presented in 2003 at the American Public Health Association tested Plan B's safeness and effectiveness on girls from thirteen to sixteen years old as compared to adult women. The study reported that, "98% of the teenage girls used the drug properly and returned to their normal menstrual period in the same timeframe as the adult women," showing teens as no more likely to misuse the drug as adults (Schorr). The occasional side effects teen girls experienced in the study matched the side effects of the adult women. Plan B's side effects—which are no worse than the stomach flu—include: nausea, headaches, tiredness, dizziness, lower abdominal pain, or breast tenderness. Furthermore, only 24% of women who use Plan B even feel nauseous and a mere 6% throw up, both of which can be prevented by over-the-counter anti-nausea pills such as Dramamine or Bonine ("Answers to Frequently Asked Questions"). This information, combined with the results of studies conducted on teen girls, shows that adolescents can safely administer Plan B, and their bodies will respond appropriately and effectively to this drug.

Another concern with adolescent over-the-counter access to Plan B includes the argument that it will increase the use of emergency contraception as a primary method of birth control. A study, conducted in 2000 by Dr. Tina Raine of the University of California San Francisco, looked at female clients aged sixteen to twenty-four and showed that "women with access to EC typically do not abandon regular contraception or use their chosen method less consistently" (Camp). Therefore, this study suggests that just because a girl or woman can obtain Plan B at a pharmacy over-the-counter, does not mean she will be more likely to use it. Furthermore, the fact that the availability of emergency contraception does not lower the use of regular birth control methods suggests that easier access will not cause women to rely on Plan B as a primary means of contraception. Planned Parenthood's brochure, handed out with the drug, recognizes the opportunity to educate women by saying, "Emergency contraception should not be used repeatedly because it is less effective than ongoing, correct use of birth control methods" (Planned Parenthood). Menstrual irregularity, an annoying but non-serious side effect of repeated usage of Plan B, may also deter women from using it on a regular basis. Plan B's availability does not appear to reduce safe sex in women regardless of age.

Over-the-counter access to Plan B also does not increase the risk of STIs associated with unsafe sex and decreased condom use. The same study by Dr. Raine showed no decrease in consistent condom use or increase in unprotected sex

RHETORIC

when emergency contraceptive users, ages sixteen to twenty-four, were interviewed six months later (Raine). Plan B does not increase a woman's tendency to have unsafe sex and put herself at risk for STIs. In fact, more women "reported not having unprotected sex and using condoms consistently at follow-up as compared with enrollment" in the experiment (Raine). Most likely this statistic stems from the fear experienced by women narrowly avoiding an unwanted pregnancy through the use of emergency contraception and leads to safer, more protected sex in the future.

As over-the-counter access to Plan B has not been associated with an increase in unsafe sex, its availability also does not appear to increase sexual behavior. Studies in both the United States and other countries have shown that increased knowledge or access to Plan B does not promote promiscuity. One such study examined "3794 male and female adolescents in Great Britain" who had over-the-counter access to Plan B (Camp). While the experiment was shown to "[increase] levels of knowledge about EC . . . there were no differences observed in sexual activity or in frequency of use of EC at a six-month follow-up" (Camp). These findings demonstrate that simply providing teens with knowledge about emergency contraception, combined with the ease of over-the-counter access, does not make teens more likely to utilize Plan B.

Some opponents claim not that over-the-counter access to Plan B will promote promiscuity, increased use, or unsafe sex in teens, but that the patient to patient counseling lost by not requiring teens to get a prescription will be most detrimental to their sexual health. However, advocates note that allowing teens access to over-the-counter Plan B could "provide an educational opportunity . . . the package insert for emergency contraception might include information about the risk of STI during unprotected intercourse, as well as a suggestion that the patient follow up with a health care provider" ("Pro & Con"). In this way, the health counseling associated with a doctor's visit is not lost. Also, nine states, including California, have led the way by passing "legislation [to allow] specially trained pharmacists to provide Plan B to women without a doctor's prescription ("Answers to Frequently Asked Questions"). These specially trained pharmacists could administer the immediately-needed drug, along with a referral to see a doctor for a later date, so that over-the-counter access to Plan B would not eliminate the essential counseling that accompanies its distribution.

Distributing Plan B to teens does not implicitly support unprotected sex, but instead deals with a realistic problem all sexually active women must face. It can be required for a variety of reasons, in addition to having irresponsible, unprotected sex, including: a broken condom, a missed pill, a missed shot, a diaphragm slipped, or even rape (Planned Parenthood). By selling condoms without age restrictions, the government does not encourage minors to have sexual intercourse and disregard abstinence, but merely provides a tool which protects the health of its citizens. In the same manner, emergency contracep-

RHETORIC

tion protects citizens of any age from unwanted pregnancy. The only difference lies in the fact that a condom serves as a preventative measure and emergency contraception literally serves as a “plan b” when needed in extreme, but very realistic, unforeseen situations regardless of age or level of responsibility.

Removing the age restrictions surrounding Plan B has the potential to prevent hundreds of thousands of teen pregnancies every year. This legislature would be extremely beneficial to teens because “the costs of carrying a pregnancy to term are highest for teenage girls who, as a result, are more likely to drop out of school and live in poverty” (Frantz 4). Teens are already able to obtain Plan B at Planned Parenthood or the doctor’s office. The change would only increase accessibility through more locations and hours, which could significantly reduce the number of unwanted teen pregnancies. The benefits of selling Plan B over-the-counter without age restrictions consistently outweigh any remaining arguments against it.

The introduction of the birth control pill in 1964 was greeted with an uproar of opposition. “The emancipation of women from their traditional roles” came as a direct result of their ability to control having children and forever changed our society (Fielder 87). The morning after pill further places that power into the hands of women—young or old. Getting rid of age restrictions is endorsed by many prominent U.S. health organizations, nine states, as well as many other countries throughout the world. By banishing age restrictions on Plan B, we take the first baby-step to reducing the rate of teen pregnancy in America.

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RHETORIC

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