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Letter from Australia

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present and future medical care (and the near future, at that) will be dependent on these developmental programs. To reiterate, these programs are expensive — and they cannot be carried out by the physicians or the hospitals alone. They need the active participation, recognition and support of the community. These are community projects.

In a realistic way, therefore, we as physicians must sedulously adhere to the ideals and dreams which attract us to medicine and not be influenced to the point of surrender by attempts to entangle us in a morass of mediocrity, or by the distractive cries of "we must be business-like," "let's avoid waste by reduplication," and "we must pay off the interest on the capital debt." Certainly these are important practical matters but medicine cannot be run by business techniques and in accord with business criteria. Medicine is not a business. If it were, we would only do procedures which provided a financial return. As applied to the laboratory, for example, we would perform urinalyses and blood counts only and not be bothered like aldosterone determinations or immunoassays of insulin. Members of the community would tolerate a physician who behaved professionally only by the desire for financial reward.

We — both the responsive person and the physician, particularly careful not to create repressing and planned rigidities, for that path surely leads to early moral bankruptcy — must be allowed to allow the possible lay person to plan and carry out imaginative hospital planning commissions, hospital boards, medical school, county or state medical societies or committees to create represing and planned rigidities, for that path surely leads to early moral bankruptcy.

When I read the recent work of Whitelaw (J.A.M.A. February 28, 1966) on the long-term effects on the patient of the contraceptive pill, I meditated on the traditional wisdom of the Church in refusing to be put off balance by each of the latest contributions of "science" in turn when they destroyed unjustly the lives of babies.

TB AND HEART FAILURE

When I was a student, the teaching of medicine everywhere was that, should a patient with TB or heart failure become pregnant, abortion was necessary to save the mother. Somebody else's dictum had said TB is worse during pregnancy and somebody else's dictum had said heart failure is made worse during pregnancy. Such situations were ideal states for statistics — it would have been the simplest thing in the world for a medical school to arrange to treat every second patient with abortion and compare the results in 100 aborted versus 100 who were not.

But the doctors who really thought abortion necessary were not allowed by their consciences to deny to their patients the correct treatment. There were always a few doctors forbidden by the patient to abort, or who did not through ignorance or negligence or carelessness. And observant clinicians discovered that the number of TB and heart patients who did get worse during pregnancy was surprisingly large.

PITT: MATERNAL RUBELLA

This is Australian and almost topical: it has to do with an editorial in Medical Journal of Australia (M.J.A.) of November 17, 1965 which begins:

The three papers by David Pitt, recently published in this Journal, mark the completion of a prospective survey of the results of rubella in pregnancy which Pitt initiated almost ten years ago. Because of the great difficulty in collecting an adequate number of fully documented patients for a prospective survey, this is likely to remain one of the definitive studies of the epidemiology of the congenital rubella syndrome. Though some other series deal with greater numbers of cases, very few rival it for thoroughness of documentation of the individual cases, and in some respects the audiologcal data break completely new ground.

However, medical progress does not stand
still. In the third paper of their triad, Pitt and Keir list under six headings the recent advances in the study of rubella which have enormously extended our understanding of the congenital rubella syndrome. First among these is the isolation of the rubella virus in 1962... Doubtless most of you know, or know of, David Pitt, ex-master and official of Guild of St. Luke, whose work on rubella has made him a world leader.

A scientific breakthrough in the true medical tradition was that of Sydney's (Sir) Norman Gregg (Trans. Aust. Ophth. Soc. 1941). The ten years after brought no advance but only a unanimous agreement among Australian scientists (and many in U. S. and Britain) that—

to save her worry—abortion of every pregnant woman afflicted with rubella was the only thing.

In Australia an epidemic of rubella occurs every year or two. By 1951 the abortions must have amounted to hundreds; nobody knew the true incidence of foetal malformations; lives and clinical material were being sacrificed on a vast scale. I pointed this out in letters to M.J.A. on January 21 and April 21, 1951.

Pitt was a general practitioner and editor of General Practitioner of Australia and New Zealand until 1961. In 1952 Pitt received the help of Melbourne's Chair of Obstetrics and several times circumscribed Australian gyps and obstetricians; 665 agreed to notify him of cases of rubella in first four months of pregnancy. By 1957 he had 47 cases and in a preliminary report "Criticisms were made of high risk figures which had been given by some early Australian workers..."

In his latest paper (M.J.A. October 30, 1965) Pitt was able to write:

103 children (in first six weeks) of rubella and antenatal rubella were followed... 100 of these have survived and are now aged between four and eight years... the total incidence of abortus... has been... 23.8... in first four weeks... 53% from fifth to twelfth week...

The final quotation from him is his 1961 paper... in only 19 (out of 61) cases was termination of pregnancy carried out; this... illustrates the change in medical practice... since the introduction of rubella was practically a no event procedure in the country.

**ROCK: THE TIME HAS COME**

Up till World War II drug would not reach the market if not approved by the senior physicians (internists) the most intelligent and responsible doctors who decided what treatment (including surgery and endocrinics) was good for the patient. The senior physicians decided what specialties were of most use to the patient and in medical education; they decided the scope of each specialty. The powerful hormone progesterin has been known for 40 years and I could not imagine any responsible doctor approving its release without exhaustive trial over five years.

Until I read The Time Has Come in 1963, I had imagined the Linacre Quarterly book was composed of some wondrous new drug. I imagine my sense of anticlimax when I discovered that Rock's claims applied only to progestin, which I had known of since a postgraduate course in physiology in 1934. "But" my better sense told me, "before recommending its release Dr. Rock has doubtless given it to hundreds of women for several years."

My confidence that Rock had thoroughly tried progestin was shaken recently when I read Morgan Mintz's statement in The Therapeutic Nightmare (p. 272) that FD had released Enovid when it had been tested on only 132 women for a year continuously. The Medical Letter of June 10, 1960 said "No physician can feel completely safe that long-term use will prove safe for all patients." Of 61 professors of obstetrics circumscribed by FDA, 21 advised against release and 14 "did not have sufficient data."

Armed with Mintz's data, I have been able to read more critically on pages 164-166 Rock's description of how he first tried one or more of the three approved progestins on 81 sterile women and got them approved by FDA for sterility and miscarriage prevention. Before he could have formed judicial opinions on the use of progestin for these purposes, it was released for contraception to a "much large number of women" in Puerto Rico, and later to several thousands. In 1963 more than a million were taking it.

Newke does Rock or his supporters tackle the two all-important questions (1) Is the pill 100% effective in preventing pregnancy? (2) Does the pill cause ovarian atrophy with it? Regarding 100% effectiveness a careful study of Rock's data will tell you it never was 100% effective. He says "With this regimen, we found that during the twenty days virtually 100 percent postponement of ovulation resulted."

"Virtually" is a significant word. He is talking of only 50 patients and virtually 100% could mean 45 or 47. In two excellent letters to M.J.A. of March 20, 1965 and March 12, 1966, Australian Dr. Morgan hints that in cases of pill failure the detail men have been instructed to doubt the woman's truthfulness. In his first letter Morgan reported two patients who became pregnant while taking oral contraceptive sold here as Sequens. In M.J.A. of December 18, 1965 Dr. Donald had reported a pill failure with Cvin. March 12 Morgan quotes (M.J.A. and B.M.J.) three other doctors reporting pill failures. Morgan says that one of his Sequens failures, a mother of five children, had spontaneously aborted. She started Ovulen but it caused depression and bad headaches. In April 1965 she started Ovulin but stopped in October because she felt pregnant; she was.

Three of Morgan's comments are worthy of notice:

When pregnancy does occur due to tablet failure, there is an increased incidence of spontaneous abortion.

The patient's distress caused by these "pill" failures is greater than when other methods of contraception fail, because these earlier methods were not expected to be so reliable.
I am in an even better position to know that it was a tablet failure, not a patient failure... more doctors recently are believing women rather than the manufacturers implications that failures are always due to patients forgetting doses.

Thirty years ago wild theories could not be inflicted on humanity because the word of the careful physician was law. If a doctor hears about a "side effect" from a patient or a friend it cannot be chance; it is not the truth. The daughter of a patient of mine after two years on the pill has had two ovarian cysts removed and is now sterile. She has had bouts of increased intracranial tension. I would not have taken notice of this but for two cases of post-pilular pseudotumor cerebri reported by Arben (Schweiz Med. Wschr. November 27, 1965); it is a sign of pituitary tumor cerebri reported by Earl Walker (J.A.M.A. June 1, 1964).

In my ruggedly rhymed review of The Time Has Come (L. Aug. 1964) I wrote in ignorance: "pill worketh no ill but...God effect." The ignorance was culpable; I should have known excessive doses of ovarian hormones would cause ovarian atrophy, even excessive doses of adrenocortical hormones cause adrenal atrophy.

April, 1966.

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Mellumine

3rd ANNUAL CONFERENCE
National Federation of Catholic Physicians' Guilds
Houston, Texas
December 8-10, 1966
Shamrock Hotel

Sessions will concern
PROBLEMS CONFRONTING
PHYSICIANS, CLERGY and SCIENTISTS
in HUMAN ECOLOGY

Medical-Hospital Relationships

Editor's Note: Father Flanagan, Executive Director of The Catholic Hospital Association, addressed the paper which follows to members of The National Federation of Catholic Physicians' Guilds and guests at a breakfast meeting in Chicago on June 29. This was the second annual Father Gerald Kelly Lecture which has been established to honor the noted Jesuit moral theologian who died in August, 1964. As a fellow Jesuit and associate with Father Kelly through the mutual interests of the hospital Association, it was most appropriate to ask Father Flanagan to give this Lecture. For some fifteen years Father Flanagan served as editor of the LINACRE QUARTERLY and has been friend and adviser to the National Federation equally as long. Since 1947 he has been the executive director of CHA and through his efforts the organization has become a most effective force in the health field.

I think we should not allow this moment to pass without acknowledging his unique contribution to medical moral writing. Because he learned to understand physicians; because he sought their advice in medical-moral matters, he set a new theological tone and introduced a new era of medical moral writing and filled a great void in the Catholic hospital field. His contributions to LINACRE QUARTERLY salvaged it from oblivion and sustained it during the most critical years of its existence. For these two great contributions, I am eternally grateful and I believe the readers of LINACRE QUARTERLY share my gratitude.

I spring to mind that it took me a year to decide which line of medical-moral writing I was interested in: dogmatic, Jesuit and empirical. I was a most active leader of the CHA and through his efforts the organization has become a most effective force in the health field.