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Dr. Sheridan: Your point is very well taken, Sister. I can assure you that at least the head of the Catholic Board of Education is urging this. He wants this. How far it has gone beyond there I do not know. We had a meeting with Cardinal Meyer on this very subject, but discussions were concluded by his untimely demise. Now we will have to begin again in this same direction. It may be as a central Archdiocesan project because there are parishes that just can't carry the burden. There will have to be some compensation for them.

Perhaps, Father Marren, you would like to close with a prayer.

Father Joseph W. Marren: Almighty God, we wish to glorify You by the efforts we put forth each day. We ask You to bless on all we do. We ask You to accompany the healing works of Your hands with the consoling and strengthening graces of Your goodness and mercy. We beg that You guide us, all our families, and all the work with in the end to eternal happiness with You. Amen.

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Oral Progestins and the Catholic Physician

Eugene F. Diamond, M.D.

Clive Wendell Holmes has wisely said, "A medicine should always be presumed to be hurtful. It is always already hurtful; it may sometimes be indirectly beneficial." It is axiomatic that, since a drug given to a healthy person cannot augment health but only diminish it, what kind of drugs are the oral progestins? Their package inserts suggest that many contraindications indicate definite risks in their use. They are given to healthy persons and not without contraindication. As physicians, how are we to evaluate their use against time-honored therapeutic principles?

In a recent editorial on bias in The New England Journal of Medicine, it is alleged that no participant in a therapeutic trial is ever totally disinterested in the outcome of the treatment but rather brings to it either a positive or negative enthusiasm. One great source of bias is the so-called "Zeitgeist." This accepted view of the majority, or an elite minority, about a drug may influence an investigator and make him more receptive to an observed result. The Zeitgeist surrounding "the pill" was not only medical but sociological, demographical, theological, political, and economic as well. Almost all of these agencies bring to bear upon oral progestins a positive enthusiasm.

Dr. Diamond is associate professor of clinical pediatrics, Stritch School of Medicine, Loyola University, Chicago.

It is against a background of positive bias, then, that the pill must be evaluated.

SIDE EFFECTS AND CONTRAINDICATIONS

In pregnancy, there is a hypercoagulable state related to augmented levels of intrinsic thromboplastin, Stuart factor, plasma thromboplastin component, and fibrinogen. When this hypercoagulable state is further complicated in pregnancy by stasis or slowing of blood flow, an ominous setting for thrombosis occurs. Indeed, thrombophlebitis and thromboembolism are well recognized complications of pregnancy.

It has been shown that the hypercoagulable state of pregnancy is reproducible, at least in part, by the administration of oral progestins. As a matter of fact, hematologists at two centers have reported the use of oral progestins in the therapy of hemorrhagic disorders—namely those due to Factor VII and Factor X deficiency. In addition, it has been shown that the oral progestins produce pelvic vasodilatation which in turn could produce slowing and stasis of venous circulation. Such an ominous combination of circumstances would make the association between oral progestins and thrombotic complications highly plausible, if not proven. As a matter of fact, recent publications fairly uniformly admit the association between oral progestins and thrombophlebitis...
while denying an association with thromboembolism.

The oral progestins profoundly affect the individuals endocrine homeostasis, probably by way of their effect on the pituitary-hypothalamic complex. The protein-bound iodine and serum corticoids are elevated during progestin therapy, while aldosterone secretion is increased, urinary corticoids are diminished and the glucose tolerance curve is altered. Considering the rudimentary state of medical knowledge in the area of endocrinology (particularly the delicate interaction and reciprocal inhibition among glands), the use of such a disturbing drug is potentially explosive. It has been suggested that the fact that the pill might provoke diabetes in certain susceptible individuals should be considered a "blessing in disguise since it enables early treatment." Most of us would be surprised to know that it is a blessing to get diabetes at 30, rather than at 60.

With regard to the hepatic effects of the drug, the report of the Puerto Rican field trials discloses fairly frequent abnormalities of bromsulfaHen causes some anxiety as to the effect of long-term use of the pill on hepatic function and, as a matter of fact, reports of jaundice during therapy are now being published with regularity.

Most of the oral progestins now on the market are 19-nor-steroid derivatives. Since they have the 17-OH group in the beta position, they have an estrogenic effect similar to that of methyltestosterone. When given in the usual dosage to women during the first eight to twelve weeks of pregnancy, they can and do produce masculinization of the fetus. One experience indicates that about 15 percent of women will become pregnant during the time they are on progestins, this places a significant number of male fetuses at risk in a nation where millions of women are taking the pill.

DOCTOR-CLERGY COLLABORATION

Because this is a potent drug, it would seem imperative that it always be given under the careful supervision of a physician. The impetus for the dispensing of such a drug should never come from the patient or from a clergyman. No priest, in or out of the confessional, should ever recommend the pill. To say that the priest does not recommend the pill but only "refers the patient to her physician" truly begs the question. Against the background of what may seem a poignant and urgent family situation, medical arguments for refusing the pill may seem specious and pedantic. It is certainly to be expected that a priest might see an indication for family planning, or child spacing, through his counseling, but he should leave the means for achieving this end up to the family physician who, alone, knows which method would be safe and successful for what patient.

Priests as well as doctors encounter many unhappy women. Some are single, some are married with small families, some are married with large families. The pill may seem a facile solution to some situations explosive of unhappiness, particularly among mothers of large families. When such a temptation exists, it is important to remember the report from the American Psychiatric Association convention which indicated that, using the Minnesota Multiphasic Survey, 30 percent of women taking the pill had symptoms of depression.

MISSCONCEPTIONS IN FAMILY PLANNING

When women say they do not want another child, what they usually mean is that they do not wish to be pregnant for awhile, or that they do not want another noisy pre­schooler around the house. They do not mean that they wish to be sterile and they certainly do not mean that they want time to save for the next child's college education. In this day of "buy now, pay later," it is ridiculous to assume that a postponing percentage of our population still has next child on the basis of economic considerations to materialize eighteen years hence. Parents and physicians must help young couples realize that it is possible to grow apart as well as together in marriage. The last twenty years of their lives will be just as long as the middle twenty years.

The average American woman now completes her childbearing by age 26, which means that by 45 or 50 she will be mistress of an empty home and a relatively empty life. When I am told of the great chaos and anguish being caused by super­numerary and unwanted children, I must say that I cannot verify such a situation in the last fifteen years of treating parent-child relationships. In a family constellation in which the father's job is dehumanized by automation and the mother's work stripped of creativity by modern gadgets and mixes, the children are frequently the only access parents have to a vitality and a vicarious meaning in their lives.

OVER-PopULATION CHALLENGE

I was raised in the era of apologetics and I will admit to some difficulties in adjustment in this age of the search for a consensus. I am particularly anguished by those who say that the only difference between the Catholic position and the modernist position is a matter of means to a common end. I doubt this very much. I doubt that the average Catholic is ready to adopt the contraceptive mentality. We are separated from the modernist view by formidable obstacles.

First of all, we are separated by a reverence for life which prevents our accepting their views on abortion—therapeutic or otherwise.

Secondly, we are separated by a reverence for the human body which prevents our accepting their views on sterilization—voluntary or otherwise.

Thirdly, we are separated by a reverence for God which makes their tasteless and mechanistic methods of sex education unacceptable and repugnant.

Finally, we are separated by a reverence for God which makes us entirely unable to accept their "new morality," woven out of the fabric of the old immorality and made
The performance of the spiritual and corporal works of mercy is as ancient as the Church itself, dating back to our Lord's lifetime when He was about doing good and healing service.

Our Lord has said that at the final judgment we shall be held accountable, not for our knowledge and wisdom, but according to whether we have performed all the works of mercy toward our neighbor—that neighbor with whom He has identified Himself.

Missionaries in far-flung areas of the world bring home the message of Christ ever so effectively by concrete manifestations of mercy. Thereby, the theology of the Head precedes the theology of the hand—the ministering hands of mercy in the service of the Church.

And who else can best typify these ministering hands but medical missionaries? In response to the late Pope John XXIII's earnest cry to the Latin America, medical missionaries—religious and lay—were among the first to respond to the challenge. From all over the world they have come to Latin America bringing with them their intelligence, experience, spirit of abnegation, and Christian creativity, and ready to help overcome the woeful problems of ignorance and disease and to spread the joyful Christian good news of faith, hope, and love.

To speak about one prominent segment of this vast armada, there are English-speaking groups from the United States, Canada, Ireland, and the Philippines—doctors, nurses, hospital administrators, midwives, practical nurses, and medical technicians—religious and lay, male and female—laboring in Peru and Bolivia. Their work ranges from the barren Pacific coast of Peru to the frigid zones of the Andes Mountains at elevations close to 14,000 feet above sea level, down to the teeming, humid jungles of the Amazon, days away from civilization.

These sturdy people operate clinics, dispensaries, and hospitals from one-room outposts to a 1,000-bed modern complex with residents, interns, nursing school, and complete laboratory facilities and staff.

Drawn together by the bond of common problems, a group of 20 of these health workers, representing 10 religious communities, met for the first time in 1963 in Cochabamba, Bolivia to share their mutual