

Under what circumstances, if any, is the use of oral contraceptive pills as hormonal agents, morally justifiable for indications other than contraception?

SHORT ANSWER:

The short answer to the question is that, under certain conditions, hormonal agents can be used to treat medical conditions under the principle of double effect.

Here we quote Pope Paul VI in *Humanae Vitae* #15:

“The Church, moreover, does allow the use of medical treatment necessary for curing diseases of the body although this treatment may thwart one’s ability to procreate. Such treatment is permissible even if the reduction of fertility is foreseen, as long as the infertility is not directly intended for any reason whatsoever.”

An example of the above might be the short-term use of hormonal agents to control life-threatening hemorrhage caused by a hormonal imbalance.

This quote, however, raises several issues for consideration and discussion that must inform the decision on whether to use hormonal agents for medical reasons, and we will discuss them in 3 areas here.

Are the hormonal agents that I am using only anovulants that reduce fertility, or are other mechanisms of action at play?

Hormonal agents are not just anovulants (block ovulation), but can have a significant rate of postfertilization or abortifacient effects.

To be clear, if the patient is not sexually active, avoids the fertile time, or is known to be sterile then there is no moral issue with using hormonal agents, since there is no chance of human embryos being created. However, if a patient is sexually active during the fertile time, and has normal fertility potential, then there can be postfertilization or abortifacient (induced loss of an human embryo) effects.

Since there is known failure rate (that is, a known rate of pregnancy) for all hormonal agents, there must be some rate of breakthrough ovulation which raises the possibility of fertilization. Studies have shown that the breakthrough ovulation rate or the suspected rate of postfertilization effects can be significant. The rate of fertilization of intrauterine devices (IUDs) per cycle is estimated to be between 4.1-8.1% for the

Copper IUD, though the pregnancy rate is 0.1-0.5%. With the levonorgestrel (Mirena ®) IUD, the fertilization rate is up to 14% per cycle, and with a clinical pregnancy rate of 0.1 per 100 women years, the levonorgestrel IUD is estimated to lead to a 99.9% loss rate of fertilized ova[1]. So there is a significant rate of postfertilization or abortifacient effects with IUDs. The rate of breakthrough ovulation with oral contraceptives is between 2-40% (2% for high dose combination OCPs and over 40% for traditional progestin-only pills)[2], so again the rate of postfertilization effects can be significant, especially over time.

Is my intention enough to justify the use of hormonal agents, since I do not desire the effect of causing sterility or postfertilization effect?

A good intention is necessary but not sufficient to justify any chosen moral object, and does not absolve one of the need for a full analysis of double effect. Put another way, the ends do not (necessarily) justify the means.

The Pope's statement above referring to a permissible, foreseen effect indicates that the Principle of Double Effect[3] is being used to justify the use of hormonal agents for medical indications. The desired intention is not the only criteria that must be met for Double Effect. One criterium is that the moral object chosen must be neutral or good (for example one cannot murder an innocent human life in any situation even to save the life of another). In the case of hormonal agents that mimic a chemical pregnancy for symptomatic relief, the moral object chosen might be considered neutral. Another criterium is that of proportionality, so that the desired effect must be proportional to the undesired effect.

Given that hormonal agents can have postfertilization or abortifacient effects at a significant rate (especially over time), the desired effect must be proportional to the likely loss of human embryos from hormonal agents. As in our example above, using hormonal agents (in the short term) for life-threatening hemorrhage might be justified, but the (long term) use of hormonal agents for a less serious condition such as acne would not be justified.

Is there some other treatment that can be used, especially one that is treating underlying diseases of the body?

Often, the use of hormonal agents for medical indications - such as pain or abnormal bleeding - are symptomatic treatments at best, and should not be considered first-line treatment.

There may be other treatments that make the use of hormonal agents, which often only treat the symptoms and not the underlying cause, unnecessary. One example is polycystic ovarian syndrome or PCOS. Hormonal agents may produce 'regular cycles', but they are actually inducing regular withdrawal bleeds, and not regular cycles with ovulation. Also, often the most common side effect of hormonal contraceptives is abnormal bleeding (so that hormonal suppression for abnormal bleeding actually may cause what it is trying to treat or make the situation worse), which has led to many different regimens. Finally, patients may feel better with hormonal agents, but this treatment does not remove the disease, and of course does not treat infertility.

Hormonal agents are *often used without an adequate evaluation of the underlying causes* [see footnote¹]. The routine use of hormonal agents for abnormal bleeding and pelvic pain are good examples.

Regarding abnormal bleeding, a study showed that antibiotics reduced the rate of abnormal bleeding in those at risk for endometritis (60% vs 29%)[4].

Regarding using hormonal contraceptives to treat pelvic pain, endometriosis is a prime example. Hormonal suppression (in the form of birth control pills or gonadotropin-releasing hormone agonist injections) are symptomatic relief at best, and usually only for the time that they are used. There is a well-documented delay in the diagnosis of endometriosis of up to 12 years, especially for younger women and adolescents[5-7]. This is partly due to the use of hormonal suppression as both a diagnostic tool and as a form of treatment. However, recently, several investigators have pointed that the status quo is not adequate for women, and have advocated for earlier intervention[8].

Regarding diagnosis, a positive response to hormonal agents is *not diagnostic*[9]. Traditionally, it was presumed that women who felt better from pelvic pain while on hormonal suppression had endometriosis. However, we now know that the lack of response to hormonal suppression when taken for pain almost guarantees having endometriosis, especially among adolescents [see footnote²]. The American College of

¹ Philosophically, it does not make sense that a treatment that is contraceptive and abortifacient would be the ideal or preferred option to treat a disease or a medical condition.

² <http://www.obgynnews.com/single-view/endometriosis-found-in-98-of-adolescents-with-chronic-pelvic-pain/ff01a6c55e074ee763eda711107dc6d1.html>

Obstetrics and Gynecology (ACOG) states clearly: “It is important to explain to patients that response to *empiric therapy does not confirm the diagnosis of endometriosis*” (italics added)[10].

Regarding treatment, the use of hormonal suppression *does not remove the disease, does not prevent progression or recurrence, and does not improve fertility*. One of the ‘presumptive uses’ of hormonal suppression is to prevent progression of disease, with or without surgery. However, studies have indicated that the rate of recurrence after ablation of endometriosis is about the same whether or not postoperative hormones are used[11]. Further, the need for birth control pills (earlier and for a longer time period) in the adolescent years, can be a marker for more advanced disease when diagnosed later in life[12, 13], which implies that birth control pills are not very good at preventing progression. Finally, temporary hormonal suppression has been tried as an attempt to improve future fertility. It was thought that suppressing endometriosis now could be helpful in improving fertility potential later. However, this has not been shown to be true, and temporary hormonal suppression of endometriosis is not recommended to improve fertility[14].

Clearly, the status quo of hormonal suppression - which is the standard way to treat adolescents and women with pelvic pain – is suboptimal medicine. We can and need to do better for women with endometriosis. Early diagnosis and optimal laparoscopic excision has the potential to eradicate disease[15, 16], or at least to minimize the recurrence rate. Still, further research and better therapies are needed[17].

IN SUMMARY:

Medical treatment with hormonal contraceptives that *cures* diseases (and for significant indications), even with an undesired but foreseen effect of causing sterility, can be used under the principle of double effect. Hormonal agents, however, which can have significant postfertilization or abortifacient effects, often do not meet this criterium. They are often used for relatively minor indications, as long term treatment, and in situations where other treatments should be considered first.

Germain Grisez [see footnote³] offers this rule of thumb:

³ Germain Grisez, *The Way of the Lord Jesus, Volume 3, Difficult Moral Questions* (Quincy, IL: Franciscan Press, 1997), 310-311.

Might it be considered malpractice to not prescribe the hormonal agent, meaning could someone argue that you could have saved a life or avoided a life-threatening situation by using the hormonal agent? If so, then the use of the hormonal agent might be considered justifiable.

Overall, perhaps there is a need to reframe the dialogue. We should focus not just on what is prohibited, and presuming *a priori* that hormonal agents are the best treatment. Catholic teaching as it pertains to medicine should not be limiting if it is a real application of Truth and Beauty as designed by the Creator. A fundamental paradigm shift is needed where Catholic teaching in medicine focuses away from what cannot be done, to what can be done in a cooperative and restorative fashion.

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