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INDICATIONS FOR THERAPEUTIC STERILIZATION IN OBSTETRICS

WHEN IS ADVICE CONCERNING THE PREVENTION OF CONCEPTION JUSTIFIABLE?*

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I faced the first part of this problem in 1920, when I reported to the Obstetrical Society of Philadelphia forty-four cases in which I considered that sterilization was essential to the well being of my patients. On this occasion I shall report seventy-four additional operations, making a total of 118 sterilizations performed in 33,000 women admitted to the obstetric service of the Johns Hopkins Hospital up to July 1, 1928—in other words, one sterilization to every 282 admissions, or an incidence of slightly more than one-third per cent.

It must be understood that the 118 cases include only those in which sterilization constituted an essential feature of the intervention, and take no account of cases in which it was unavoidably associated with the removal of the uterus or its appendages at infected cesarean section, for myomas, for uterine apoplexy associated with premature separation of the placenta, for ruptured uterus, etc., as well as when bilateral disease of the tubes or ovaries made their removal imperative.

Before taking up the consideration of the indications followed or their justifiability, I will say a few words concerning the methods available for sterilization. Generally speaking, it may be effected by any one of four methods—by operation on the ovaries, tubes or uterus, or by the employment of the x-ray.

In the early days of gynecology, castration constituted the simplest and most direct method, but, as we gradually learned that the ovaries, in addition to producing ova, have an even more important internal secretory function, we slowly appreciated their importance to the female economy and learned to remove them only when imperatively indicated by gross disease. From time to time, various writers have advocated leaving the ovaries but so changing their situs by burying them within the broad ligaments or by so covering them with peritoneum that ova cannot gain access to the tubes. While such operations are theoretically feasible, they are difficult to perform and uncertain in result, since the slightest defect in the new peritoneal covering may defeat the purpose for which they were devised.

With the development of our knowledge concerning the destructive action of the x-ray on germ cells in general, its employment as a means of producing sterility has been suggested and to some extent employed. Without going into detail, it will suffice to say that the method has proved unsatisfactory where permanent sterilization is indicated. On the other hand, when relative, temporary sterility is desired, the method possesses the great advantage of avoiding any operative procedure; but at the same time it is burdened by the handicap that serious fetal abnormality may result should a damaged egg be fertilized.

Consequently, for practical purposes, our means of producing permanent sterilization are restricted to operations on the tubes and the uterus. Theoretically, tubal sterilization may be effected by one of the following procedures: (*a*) simple ligation; (*b*) double ligation and section between the ligatures; (*c*) section of the tube, and burial of its proximal end between the folds of the broad ligament or in the depths of the uterine musculature; (*d*) excision of the entire tube; (*e*) excision from the uterine cornu, and (*f*) various procedures for so displacing its lateral end that ova cannot gain access to it.

Simple ligation of the tube for purposes of sterilization was first mentioned by Michealis early in the last century, and seriously proposed by Blundell in 1834 as a suitable means of obviating the necessity for repeated cesarean section. It was first practiced in 1880 by Lungren of Toledo, Ohio, and afterward extensively employed. Experience soon showed that it was unreliable, and also that no better results followed double ligation, with or without section, or even the excision of the part of the tube lying between the ligatures. This was conclusively shown by the experience of Zweifel, who performed the latter operation after a cesarean section and was surprised to have the patient return pregnant. At the time of the second section, he found that all trace of the ligatures had disappeared and that the cut ends of the tubes had reunited and had reestablished normal conditions.

Tubal sterilization has given rise to a considerable literature in which the names of Nürnberger and Kalliwoda play a prominent part. The latter stated that four failures had occurred in a series of sixty-seven cases in Döderlein's clinic, in which it had been attempted by doubly ligating the tubes; furthermore, that fourteen failures had occurred in seventy-five cases which he was able to collect from the literature—an incidence of more than 18 per cent.

Fraenkel, Nürnberger, Köhler and others have investigated the cause of such failures by experimental work on animals, as well as by the histologic examination of tubes removed from patients. They found one of three explanations: (1) that the tube had so retracted within the ligature that its lumen was not obliterated; (2) that the ligature had cut through the tube wall, usually at the site of the knot, so that a fistulous tract resulted which permitted the ingress of ova, and (3) that, while the tubal lumen had been effectively compressed, its

* Read before the University of Washington, July 20, 1928.

mucosa had formed a number of isolated passages, somewhat as in follicular salpingitis or as in the adenomatous formations that sometimes develop in the proximal end of chronically inflamed tubes. Consequently, as the result of clinical experience and of experimental work, all attempts to effect sterility by ligation or severance of the tubes have been abandoned.

With this in mind, I attempted to overcome the difficulty by doubly ligating and severing the tube several centimeters from the uterine cornu, burying its proximal end between the folds of the broad ligament, and carefully closing the wound with fine silk sutures. Sometimes the operation succeeded brilliantly, but in other cases the broad ligament was so delicate and friable that the results were uncertain. Irving has recently described a technic in which the proximal ends of the tube are buried in the uterine muscle. His procedure appears to be simple and satisfactory, but only time and experience can show how effective it will prove.

Consequently, the only practical routine method of tubal sterilization consists in excising its proximal end from the uterine cornu by a wedge-shaped incision, and carefully closing the wound with fine sutures. This procedure is readily applicable in pregnant as well as nonpregnant women. In the early months, it is done after emptying the uterus by abdominal hysterotomy, and in the later months following cesarean section. In such cases there may be a good deal of bleeding, unless one takes the precaution to ligate the uterine vessels at the cornu before making the excision. The results are satisfactory, as the only possibility of failure consists in the formation of a fistulous tract in cases in which an old inflammatory process of the uterine cornu or of the proximal end of the tube has been overlooked.

In recent years, this is the method of tubal sterilization which we have employed, and, as far as our "follow up" indicates, it has given satisfactory results. As I have had no experience with the several methods of displacing the lateral end of the tube or of covering it with peritoneum, as described by various continental writers, I shall not consider them.

As early as 1834, Blundell in the following words advocated the removal of the uterus as a means of effecting sterilization, and demonstrated its efficiency in animals: "In speculative moments I have sometimes felt inclined to persuade myself that the dangers of cesarean operations might, perhaps, be considerably diminished by the removal of the uterus." This procedure was not, however, employed until after Porro had described his operation in 1877, and naturally did not enjoy any great vogue until after the present methods of supravaginal hysterectomy had become perfected.

Sterilization can be effected either by complete or by supravaginal hysterectomy, and ordinarily the latter is preferable on account of its simpler technic. Early in my career, I recognized that convalescence following cesarean section terminated by supravaginal hysterectomy was much more satisfactory than after the apparently simpler conservative operation, and consequently I resorted to it, and still continue to do so, whenever a reasonable indication presents. Years ago, when the results following cesarean section were less good than at present, I felt justified in removing the uterus at a second section for contracted pelvis; but, as the prognosis improved, I no longer think of suggesting it until a third or fourth operation becomes necessary, and then I merely suggest the possibility of sterilization to intelligent patients, but urge it in the case of less intelligent women. In this event, I explain that it can be effected in one of two ways, and that menstruation will continue after one but not after the other. If the patient expresses the desire to continue menstruating, I sterilize her by excision of the tubes, but, if she is indifferent in the matter, I amputate the uterus and leave the ovaries and tubes in situ, feeling sure that the convalescence will be smoother than if the more conservative procedure were adopted.

Likewise, when sterilization appears advisable before the child has reached the period of viability, or even in the nonpregnant woman, I pursue the same course with a clear conscience.

It is my experience that white women are much more concerned regarding the preservation of the menstrual function than colored, and consequently in the statements which follow it will be found that supravaginal hysterectomy was employed much more frequently in the latter.

On analysis of the material, it is found that 118 women have been sterilized, divided as in the accompanying table.

Distribution of Patients

		Number of Cases
At term	Radical section	34
	Conservative section with tubal sterilization	32
Prior to viability	Supravaginal hysterectomy	27
	Hysterotomy with tubal sterilization	18
Nonpregnant	Supravaginal hysterectomy	4
	Tubal sterilization	3
	Total	118

An analysis of the indications reveals that forty-eight of the sixty-six sterilizations at term were done on account of such disproportion between the size of the head and the pelvis that repeated cesarean section was required. Except for a few instances years ago when sterilization was effected at a second section, the remainder were performed at the third or fourth section. In twenty-six patients it was effected by supravaginal hysterectomy and in twenty-two by a tubal operation following conservative section. In the first part of the series the proximal ends of the tubes were buried between the folds of the broad ligament, while for the past eight years they were excised from the cornu by a wedge-shaped incision. It will be noted that approximately 90 per cent of the radical operations were done in colored women, as compared with 45 per cent when the tubal method was employed, thus emphasizing the slighter importance the colored women attach to preservation of the menstrual function.

Concerning the justification of sterilization to prevent the endless repetition of cesarean section on account of contracted pelvis, it may be objected that we have no right to suggest it, or even to perform it at the request of the patient, or, as one of my friends expressed it, "to arrogate to ourselves the attributes of the Almighty." Doubtless such a point of view may be correct, but I have been unable to convince myself of it.

The great majority of such cases have occurred in colored women, many of whom were of such rudimentary intelligence that there was no assurance that in moving about, as they constantly do, they would take the trouble to place themselves in competent hands when again pregnant, with the result that the uterine wall,

weakened by previous incisions, might rupture with a fatal outcome. On the other hand, in the case of intelligent women, one frequently has to face the request that further pregnancy be made impossible at the time of the first section, so that the pressure for it becomes unbearable by the time the third section becomes necessary. In general, I feel that any woman who is seriously handicapped by a contracted pelvis has done her full duty to the community if she has given birth to three living children, and is entitled to be freed from further danger from that source.

As time goes on, I have become more and more impressed with the serious effect of pregnancy on women suffering with chronic nephritis. Many such patients are put in serious jeopardy at earlier and earlier periods in each successive pregnancy. Many pregnancies end spontaneously in the birth of a dead child before the period of viability or require active intervention at a later period. Moreover, in many instances the return to relative well being requires a longer time after each repetition of pregnancy, and it sometimes happens that the patient dies within a year after her last delivery. With such experience in mind, I have become more and more liberal in recommending sterilization to such patients, more particularly as many of them are mothers of large families, and it seems to be our duty to preserve them as long as possible to care for their living children rather than to allow them to be sacrificed for the sake of others not yet born. It sometimes happens that the condition of the patient is so serious at the time of delivery that it seems wise to limit our intervention to the greatest possible extent. In such cases we instruct the patient to return for sterilization as soon as she realizes that she is again pregnant, and occasionally we intervene before she becomes so. Naturally, we give such patients contraceptive advice, but only in rare instances does it prove effectual.

Our figures show that we have sterilized twenty-eight women suffering from chronic nephritis. Nine were delivered by cesarean section at or near term, of whom four were sterilized by means of supravaginal amputation of the uterus and five by cornual excision of the tubes. Furthermore, nineteen were sterilized before the period of viability was attained: twelve by supravaginal amputation and seven by abdominal hysterotomy followed by excision of the tubes. It should be noted that considerably more than one half of these women were white.

At first glance it may appear that such treatment is too radical; but when it is remembered that the twenty-eight operations were spread over thirty years it becomes evident that the radicalism is more apparent than real, and I have no hesitation in stating that not a few patients who were not so treated would be alive today had we been more radical.

The next great indication is for mental disturbances, as well as for various social conditions, but as such indications have been employed only during the past eight years, their consideration will be deferred until after I have completed the enumeration of the more generally accepted indications.

Following these, the next most common indication was afforded by serious disease of the heart, which we considered incompatible with further pregnancies. Most of these patients suffered from mitral stenosis, either alone or associated with other cardiac lesions, and many were multiparas who had done increasingly badly with each successive pregnancy. There were twelve such patients; five were sterilized at the time of cesarean section, six before the period of viability of the child, and one after the completion of the puerperium. Two thirds of the sterilizations were effected by radical intervention and the remainder by excision of the tubes.

Tuberculosis afforded the indication for intervention in nine patients, and in each sterilization was effected relatively early in pregnancy: eight times by the radical and once by the tubal technic. All of these were multiparous women in whom attempts at contraception had failed, and intervention was done not so much in the hope of curing the disease as to prevent its exacerbation in subsequent pregnancies and thereby to preserve the woman to care for her family as long as possible.

In general, I may say that we have become increasingly conservative regarding the induction of abortion in tuberculous women, more particularly since an analysis of our material by Bridgman and Norwood in 1926 showed that more women were alive at the end of three years when the disease had been allowed to pursue its course than when pregnancy had been interrupted. Naturally, such a conclusion may be fallacious, as intervention was practiced only in the more severe cases, in which the prognosis was inevitably more somber.

Under the heading "various" I have brought together three cases, in two of which the indication for intervention was clear, while in the third it is possibly subject to criticism. In the first two instances, one kidney had been removed some time previously, and one patient came to us suffering from severe chronic nephritis and the other from profuse hematuria, for which no satisfactory explanation could be found. In both instances sterilization was effected by removal of the pregnant uterus. The third patient, a forlorn specimen who had had the appendages on one side removed and the uterus suspended, and had complained of such abdominal pain during pregnancy as to make life unbearable, came to us with a sacculated uterus which demanded cesarean section in order to prevent rupture of the uterus. At the same time, I sterilized her by the cornual excision of the remaining tube.

Thus far, I assume that few will take serious exception to the indications enumerated, and will admit that in most of our cases, at least, sterilization was justifiable; but I am not so sure that they will follow me in the group of cases which I am about to adduce.

As our prenatal and social service nursing developed, we have had an increasing opportunity to learn more of the constitutional, psychologic and material peculiarities of our patients. At the same time, the development of the social welfare activities of the psychiatric department has brought the members of that staff into contact with all sorts of maladjustments and human misfits, with the result that scarcely a month passes without one or more patients being referred to me with the statement that their mental condition will be still further depressed by the continuance of pregnancy, or that their intelligence is of so low a degree that they will be unable to care for their children when born, and that the latter will inevitably become wards of the state and probably undesirable citizens as the result of inherited and congenital stigmas.

My first reaction was to regard such cases with suspicion and to feel that the recommendations for intervention were in part due to the overdevelopment of civic consciousness which sometimes characterizes social and psychiatric workers. I made a point, however, of looking personally into all such cases, with the result

that I slowly became convinced that a large field exists for collaboration and that many of the patients presented problems demanding the wisdom of Solomon for their solution, and which are not covered by the current teachings of obstetrics or medical jurisprudence. Furthermore, I found that I was brought into contact with many questions of eugenics which I could not face without sympathy, but whose practical implications I could not follow without doing violence to my inherited and acquired medical conscience.

The result has been that I have declined to intervene in a large number of cases, but in a small proportion I have felt that I could do so with a clear conscience; and indeed the basis for this paper is a desire to take stock of what we have done and to ascertain the reaction of my colleagues as to it. In any event, I have been so impressed with the importance and magnitude of the problem that I am attempting to raise money to defray the expenses of a scientific inquiry into the interrelations between feeblemindedness in a large series of pregnant women and the welfare of the community.

After these introductory remarks, I may say that during the past seven years we have sterilized fifteen patients for mental or psychiatric indications, as well as four others for so-called social indications. The fifteen mental indications are as follows:

Four cases, pronounced feeblemindedness (cases 1, 2, 3, 4).
Four cases, dementia praecox (cases 5, 6, 7, 8).
Three cases, epilepsy (cases 9, 10, 11).
Two cases, frank psychosis (cases 12, 13).
One case, chorea and repeated puerperal insanity (case 14).
One case, postencephalitic depression (case 15).

Two of these patients were sterilized by tubal excision following cesarean section, seven during the course of pregnancy before viability of the child, and five some time after the last delivery.

It would lead too far afield were I to attempt to give detailed histories of each case, but I cannot refrain from mentioning several in order to give an idea of the sort of problem one has to face:

Case 2.—A colored girl, aged 19, had a generally contracted rachitic pelvis of such degree as to afford an absolute indication for cesarean section. She was referred to us with the statement that she had a mental age of 8 years and had several times been arrested for petty thievery. She had a positive Wassermann reaction, and during her pregnancy spent six weeks in the service recovering from a severe toxemia. During that time we had abundant opportunity for observing her and the unanimous opinion was that she was the least intelligent patient who had been in the service for years, and that it was improbable that she could care for her child. Cesarean section was performed at term followed by wedge-shaped excision of the tubes.

Case 3.—An imbecile white girl earned $5 a month and her keep caring for chickens on a farm. She became pregnant by the county drunkard and was brought to us by a social worker with a letter from the state's attorney of the county advocating abortion and sterilization. He stated that if this was not done he would be compelled to commit her for life to an institution for the feebleminded, while otherwise she could continue her work and be self-sustaining. After taking her photograph, which gave a "speaking" picture of her mental state, and going through the necessary legal formalities, we amputated her uterus with a good conscience.

Case 4.—A white woman in the late thirties came to us in her tenth pregnancy. She was a well born woman who had married beneath her and, without any particular vices, had become less and less intelligent with each pregnancy. For the past few years her children were cared for by others, and she was brought to us with the statement that her mental age was between 8 and 10 years and was likely to become less if she had more children. She was allowed to go to term and was sterilized a month after delivery by a tubal operation.

One of the four patients with dementia praecox was sterilized at the time of cesarean section, and the other three early in pregnancy. All but one of these women had served terms in insane asylums, and the other was the daughter of a woman hopelessly insane from the same disease in an asylum in another state. All of them were referred from the psychiatric department with the statement that they were incurable, and that their deterioration would be hastened by the repetition of pregnancy. Consequently we felt that we would benefit them and the state by intervention.

Each year a number of epileptic women pass through our hands and we have gained the impression that, in general, epilepsy has no effect on pregnancy or vice versa. Nevertheless, we have sterilized three patients sent to us by the psychiatrists with the statement that one had suicidal tendencies and that all showed signs of mental deterioration, and that it was probable that the continuation of pregnancy would hasten the process. After consultation, two of the patients were sterilized by radical procedures and the third by excision of the tubes.

The last indication that I shall mention in this connection was afforded by profound mental deterioration following epidemic encephalitis. This patient, who had had several children and was previously unusually intelligent, had become torpid and depressed following recovery from encephalitis and was in constant dread that she might become pregnant and be unable to care for her child. Consequently, on the advice of the psychiatrists she was sterilized by amputation of the nonpregnant uterus. It might be added that the most complete source of information concerning the relations between this disease and pregnancy is to be found in Roques'[1] recent article.

Passing on to the so-called social indications, we have to deal with four cases, two of which were handled by cesarean section at term, one by abdominal hysterotomy and tubal sterilization, and the fourth by tubal sterilization one year after the last delivery. I will give a brief abstract of each case so that the justifiability of the course pursued can be criticized.

Case 16.—A colored woman, aged 18, with a contracted pelvis, syphilis, tuberculosis and a history of general worthlessness, was delivered by cesarean section at the end of her first pregnancy, and sterilized by the cornual excision of the tubes.

Case 17.—An unusually intelligent white woman, with a healthy husband, had previously given birth to two microcephalic idiotic children. She was three months pregnant and was obsessed by the dread that the third child would present the same deformity. When I was told about her, I stated that I should probably decline to intervene as I knew of no evidence indicating the hereditary nature of the deformity. When, however, she came to my office with her children and I saw them running about like little guinea-pigs, I was so depressed that I felt that I should urgently demand relief were I in her place. With some compunction, I did an abdominal hysterotomy followed by cornual excision of the tubes, and my conscience was greatly relieved when anthropologic measurements by Dr. Adolph Schultz showed that the embryo was likewise microcephalic.

Case 18.—A white girl, aged 20, had a generally contracted pelvis which had necessitated cesarean section eighteen months previously. At her second admission I learned that she had a mental age of 12 years and that she had great difficulty in caring for the child. Consequently, when the second section

1. Roques, Frederick: J. Obst. & Gynec. Brit. Emp. 35:1 (spring) 1928.

was done, I had no hesitation in excising the tubes from the uterine cornua.

CASE 19.—A frail colored woman, aged 27, had a kyphotic funnel pelvis presumably caused by tuberculosis. She had had two cesarean sections in another city and four spontaneous labors in our service. She was losing ground physically, had a worthless husband, and was compelled to support herself and children, but could not keep a position if she were constantly pregnant. Consequently, she was sterilized one year after her last delivery by a tubal operation.

I feel that intervention was justified in all four cases, but I am quite prepared to have others dispute it. Nevertheless, their recital serves to indicate how difficult it frequently is to arrive at a decision, and how much will depend on one's point of view and religious convictions. It goes without saying that in all such cases it is imperative to obtain written permission from the patient and her husband and, lacking the latter, from both of her parents. Moreover, in the case of mental indications in minors, particular stress should be laid on obtaining the written consent of the legal guardian, reinforced by a statement from the consulting psychiatrist. All of these should be incorporated in the history as a protection against possible legal action by the unbalanced patient. Furthermore, such precautions may have a restraining influence on the obstetrician who is inclined to allow his feelings to sway his judgment.

What are the dangers of sterilization? In general, they are slight, and are those incident to any ordinary abdominal operation. In our series there was one death, years ago, following tubal sterilization incident to a conservative section.

Is the operation always successful? This must be answered in the negative. In general, it may be said that following amputation of the uterus the only possibility lies in the accidental formation of a fistulous tract through the cervical stump as the result of infection. On the other hand, following cornual excision of the tubes, the danger is somewhat greater, as in such cases we have to consider not only the possibility of fistulous tracts due to imperfect technic but also those resulting from unrecognized chronic inflammatory processes in the uterine portion of the tubes.

That this danger is not great is shown by the fact that none of our patients have returned pregnant, as well as by the further fact that more than a half of them have returned for examination one year after the intervention and all were found to be in good condition.

The only exception in this regard occurred in the patient with the kyphotic funnel pelvis mentioned under social indications. She returned to the service on account of bleeding ten weeks after sterilization, and microscopic examination of scrapings removed by curettage revealed the presence of old hyalin chorionic villi. As the patient said that there had not been coitus for six or seven weeks following the operation, it seems justifiable to assume that she became pregnant just prior to admission to the clinic, and that traumatism at the time of operation had so damaged the product of conception that a delayed incomplete abortion was the result.

ADVICE CONCERNING THE PREVENTION OF CONCEPTION

It must follow from what has already been said that I believe in the justifiability of contraceptive advice under proper conditions, as the more radical procedure of sterilization could be justified only after the former had failed, or in case we are persuaded that our patient is too unintelligent to follow it.

I feel, however, that a few words on the subject are indicated, as I gather that considerable misconception exists both in the lay and in the medical mind concerning it. On reading the books of Mrs. Sanger and Marie Stopes, as well as the various propagandist publications concerning birth control, one gains the impression that new and effective means of contraception have been discovered, and that their widespread use would so improve the condition of mankind that the millenium would soon be at hand.

This is all wrong, for so far as I can gather the only relatively reliable contraceptive means at our disposal are the male sheath and the occlusive pessary. The former has been in use for nearly 200 years and was frequently mentioned by Casanova, who died in 1803, while the latter was described by Mensinga fifty years ago, although rudimentary substitutes for it had probably been in use from time immemorial.

It should be clearly recognized that even these means do not give absolute protection, and all that can be claimed for them is relative efficiency, which will sometimes fail when certainty is most essential. Indeed, it appears to me that the chief benefit which we have derived from the birth control propaganda is the belated recognition, by such writers as Stopes and Cooper, that there is no "safe time" in regard to the menstrual cycle, and that douches and medicated suppositories merely diminish the chances of conception but cannot be relied on when one is dealing with a medical indication. Furthermore, it seems to me that there is no probability that the greatest possible diffusion of knowledge concerning contraceptive methods will bring about the millenium, but that the most that we can expect from it will be a marked reduction in the size of families in the upper walks of life, but little if any change among the ignorant and unintelligent, where it is most needed.

For its effects in the former class, one needs only to consider one's friends and to note the difference in the size of our grandparents' families and our own. The same thing can be demonstrated by the fact that the graduates of our best colleges are not reproducing themselves, or by the statistics of Cattell, who found that 643 men of science in this country, with closed reproductive careers, averaged only 2.3 children as compared with 4.7 for their parents.

It should be recognized that this has come about in spite of state and national legislation, and that the central government forbids the use of the mails to information concerning contraception, forbids interstate traffic in contraceptive articles, and even prevents their importation for investigative or scientific purposes. The result is that a bootleg traffic has developed, which supplies the demand at excessive prices, which again demonstrates the impossibility of attempting to control noncriminal personal habits by law. Again, the Roman Catholic Church teaches that all forms of contraception are sinful, and in a little book on birth control written by John M. Cooper, professor in the Catholic University of America, which bears the imprimatur of Archbishop Curley, it is stated that the only permissible method of preventing conception is sexual abstinence. I shall not attempt to enter into the religious aspect of the question but shall content myself with stating that in my somewhat large experience the only difference that I can note between Catholics and others in this respect is a slight difference in degree.

Where should we stand as medical men? To my mind there can only be one answer, and that is that we must give contraceptive advice whenever it is medically

indicated, but that it must depend on our conscience as to what advice should be given under other conditions. I hold that it is just as much our duty to give such advice when medically indicated as it is to advocate the employment of any other prophylactic measure.

We must advise the multiparous woman suffering from chronic nephritis not to become pregnant, and the same applies to tuberculosis and serious heart disease. Consequently, if we feel that such advice is necessary we must give directions as to how it can be made effective, for if we do one without the other we are failing in our duty as physicians and in great part are wasting our time.

I likewise feel that similar advice is indicated when we see a patient steadily going down hill as the result of pregnancies recurring at too close intervals, as well as in certain neurotic and maladjusted women whose entire life is disturbed by a constant dread of pregnancy. Indeed, the list of indications might be considerably increased if time and space permitted.

In my experience, contraceptive advice will usually accomplish its purpose among the so-called intelligent classes, but it is almost useless among the ignorant, feebleminded and brutal, and it is in the latter particularly that we must go still further and effect sterility by operative means when necessary. Of course, it may be argued that even in the latter class continence is the true solution, and that if it cannot be attained the matter is out of our hands. If men were angels, such advice might hold; but even among the most intelligent and well meaning I hesitate to recommend continence for too long a time, as I know from experience what it means to give advice which may lead to a blasted marriage.

For these reasons I give contraceptive advice whenever I feel that it is medically needed, as I consider it far less serious than to induce a therapeutic abortion or a premature labor, which so often becomes necessary when a patient is told not to become pregnant but is not instructed as to how to avoid it. Moreover, when I give such advice, I always regret that the means at our disposal are not more efficient, and that it often must imply a certain feeling of degradation on the part of the person securing them from semibootleg sources. I feel very strongly that our state and national laws should be amended so as to make it possible for physicians to prescribe contraceptive means with the same freedom and decency as any other prophylactic or medical device, and I resent very strongly the attempt of the government to interfere in this respect, as I regard it as an unwarrantable aspersion against the integrity and bona fides of the medical profession.

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