THE TECHNIQUE
of
BIRTH CONTROL

By
WILLIAM J. ROBINSON, Ph.G., M.D.

PRACTICAL PREVENCEPTION

OR THE TECHNIQUE OF BIRTH CONTROL

Giving the Latest Methods of Prevention of Conception, Discussing their Effect, Favorable or Unfavorable, on the Sex Act; Their Indications and Contra-indications, Pointing Out the Reasons for Failures and How to Avoid Them.

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PREFACE TO FIFTH EDITION

THE change in the attitude of the people towards the question of voluntary limitation of offspring is truly remarkable—more remarkable than towards *any other social problem.* I do not mean to imply that *every* man and woman the world over is in favor of birth control; but I believe it is fair to state that every man and woman of fair intelligence and capable of independent thinking *is.* Only people who never think, who are incapable of a free thought, who are held down by superstition, by authority, by fear of punishment, in other words, only people of a low degree of intelligence, are nowadays opposed to prevenception. As a matter of fact intelligent people are bored with discussions of birth control; it is to them a *chose jugée,* an old story. What we hear people say now is: We don't want any arguments about birth control; we don't need any; what we want is the best, simplest and surest method.

And they are right. A great deal of the birth control propaganda is at the present time su-

perfluous; it is like breaking in an open door. I do not mean to say that all birth control propaganda should cease; we need it badly for the lower classes, for the people of low intelligence above referred to, and we need it to counteract the anti-birth control propaganda which has become very violent of late. But our chief occupation must now be: research, the discovery of the *ideal* prevenceptive. And that is our chief work. We are nearer the ideal than we were when the first edition of this work went to press; we have handled a certain preparation which seems in every way ideal; but it can be pronounced ideal only after its use in several hundred cases without a single failure; and this practical test it has not yet had; and therefore we refrain from pronouncing a definite opinion. But, I repeat, there is no question that we are much nearer now to the ideal prevenceptive than we were a few years ago.

To summarize: while birth control propaganda is still necessary, it is of secondary importance. Of primary importance is the PERFECTION OF PRACTICAL PREVENCEPTION.

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CHAPTER I

FOREWORD

THE AUTHOR of this volume is The Pioneer of the modern birth control movement in America. He makes this statement, not in a boasting spirit, but because it is the truth and has relevance to his competence and fitness as a writer of a treatise on Practical Prevenception. He was not only the first systematically and persistently to advocate voluntary limitation of offspring when to do so meant to draw upon oneself obloquy and ostracism and when *no one else* thought or dared to do so; he was also the first to experiment with and to compound various formulæ for prevenceptive purposes in which work his knowledge of chemistry and pharmacy was of service to him, and to furnish such formulæ, first typed, then mimeographed, then, as the demand became greater and greater, printed, to those who requested them.

For years he has been urged to incorporate his knowledge and experience in book form, discussing the indications and contraindications of the various mechanical, chemical and physiological (and surgical) methods of prevenception, pointing out the causes of the many failures and the ways, if any, of obviating those failures, and finally, summarizing his opinions as to which methods were the more reliable, which the more desirable—a method may be reliable, and yet for various reasons be quite objectionable—and which the most universally applicable. He was assured by many physicians familiar with his activities during the past third of a century, that such a book would be highly prized by the medical profession. He hesitated, first, because of pressure of other work and, second, because the time did not seem ripe. Now the pressure of non-postponable work is less than it was, and the time seems to be opportune. He therefore has written this volume, and offers it confidently to the medical profession, and the medical profession only, as a reliable and up-

to-date vademecum on the subject of Practical Prevenception.

One question may be touched upon here and answered. Isn't a book on prevenception for physicians something in the nature of carrying coal to Newcastle? Isn't a physician supposed to possess all this knowledge?

Yes! He is supposed to and he should. I have always maintained that it was just as important for a physician to know how to prevent undesirable and undesired pregnancy as it is to prevent the spread of typhoid or the contraction of any infectious disease. But alas! the percentage of physicians who know nothing, or practically nothing, about the prevention of conception is truly and tragically amazing. I have had physicians in my office from the West and the South and from small urban and rural communities in general who had not *heard* of, handled or seen a condom or a pessary! The fact that there were prevenceptive jellies, suppositories and tablets was a revelation to them. And how should they know? Such knowledge does not come by instinct or inspiration. You have to *acquire* it.

And in our medical colleges not a single word is uttered on the subject, and in all the text-books that we, as medical students, are required to study, not a paragraph is devoted to the subject. From a study of all the books on biology, physiology, internal medicine, obstetrics and gynecology, you would not suspect that there exists such a thing as prevenception (or contraception), you would not learn that to prevent conception is sometimes of *vital* importance, i. e. a matter of life and death, and that it is therefore important for the practicing physician to be familiar with the various methods and appliances necessary to prevent undesirable and undesired pregnancies. And proportionately to the general population, we get as many requests from the medical profession for prevenceptive information as we do from the laity.—This, I believe, answers adequately the question as to the need of a manual on prevenception for physicians. No class in the community needs it more. Until such a time when a course in the Theory and Practice of Prevenception becomes a regular part of the curriculum of every med-

ical college in the world, such a book should be the indispensable vademecum of every conscientious and humanitarian physician.

The numerous features which differentiate this volume and set it apart from every other attempt on this subject, will be seen even from a cursory glance at its contents.

The unscrupulous opponents of birth control, having no arguments to oppose to our unanswerable plea for voluntary parenthood, attempt to besmirch the work of the advocates of birth control by insinuating that the latter have interested motives, that they make profit on the sale of prevenceptive devices, etc. It is, I believe, superfluous to state—at least it should be—that the author of this volume has no connections whatever with any manufacturing concern, and is not in the very least interested in any special brand or appliance or formula. What he recommends can be prepared by any manufacturer or competent pharmacist.

I cannot conclude this chapter without presenting a question: Do you know of any more pitiable figure than that of a physician who tells

a woman with a dangerous heart lesion, or a mother exhausted and weakened by numerous pregnancies, labors and lactations, that under no circumstances must she become pregnant again, but to the question—what is one to do to prevent another pregnancy, has nothing to say, except to shrug his shoulders, smile embarrassedly or mutter something about keeping away from the husband? There is *nothing* that makes the laity more contemptuous of and bitter against the medical profession than just the refusal to give preconceptive advice when it is vitally needed, particularly so because they are convinced that this refusal is not due to ignorance but to selfish unwillingness. It *is* sometimes the latter, but more often it is the former —a condition which this book aims to remove.

A word about the term Birth Control. "Birth Control" is misleading. It is a translation of the German *Geburt-Regelung* and is now a permanent addition to our language, which nothing probably will uproot or displace. But it is a bad term, the worst that could have been coined. It is due to that term that prevenception (or

prevention of conception) is still so frequently confused in the popular mind with abortion. People know that by abortion they can control the number of births, by abortion they can prevent the birth of a child. Hence when they hear "birth control" they take it as a synonym for abortion. And the term is intrinsically wrong because it is not the *birth* of offspring that we control, it is the *conception* that we prevent. Prevention of conception, prevenception or conception control, are from every point of view better terms. Prevenception and its adjective prevenceptive have the advantage of being one-word terms, express exactly what we want them to express, and for reasons I explained elsewhere are much preferable to contraception and contraceptive. So, whenever we have the proper occasion, let us use the terms prevenception and prevenceptive. We cannot eliminate the misleading term, "Birth Control," from our language, but we can limit its use.

CHAPTER II

CONDITIONS IN WHICH PREVENTION OF CONCEPTION IS IMPERATIVE

This volume, intended for the medical profession and sold by subscription only, is not likely to fall into the hands of people who do not "believe" in birth control. Such people belong in the kindergarten class, and if they are not convinced of the righteousness, morality, vital importance of birth control for the individual family and the race, they should go and read such books as our *Birth Control or The Limitation of Offspring by Prevenception,* and *Small or Large Families.* There they will find all the arguments in favor of birth control, and all the objections against it answered. This volume assumes that the reader is in favor of prevenceptive knowledge, and the author therefore considers any repetition of the pro-arguments superfluous. But a brief recapitulation of the con-

ditions which render prevenceptive methods not only permissible but imperative will not be out of place.

There are physicians and laymen who maintain—and I agree with them—that any woman desiring birth control information should get it without any quizzing or questioning. The woman, they say, is mistress of her body, and there should be no undesired pregnancies. Motherhood should be entirely voluntary. While some may consider this attitude too advanced, too radical, surely even conservative physicians, unless they be a Howard Kelly or an Austin O'Malley, will agree that there are conditions in which the use of prevenceptives is not only permissible, not only desirable, but imperative both from a hygienic and moral standpoint. Not only is it permissible to instruct the patient in such cases—not to do so is *criminal;* for it is to fail in the highest function of our profession, which is to prevent suffering, disease and death.

What are these conditions? Let us enumerate them briefly.

HEART DISEASE

There are cases of heart disease in which for the woman to become pregnant is to sound her own death knell. We will be told, such women should never marry. Perhaps. But first we are not always consulted before the thing—the marriage—has taken place, and second, there is no reason for condemning all female cardiac cases to celibacy. Many women with heart disease may marry and lead a married life safely, *provided they do not become pregnant.* I well remember a case of labor to which I was called in the first year of my medical practice. As I came in, the woman, who had been married barely a year, gave a last gasp and expired. The husband told me that the doctor who had treated her told her that she must not under any circumstances become pregnant. But when they asked him what they could do to avoid such a possibility, he only shrugged his shoulders and said nothing. And the new babe was born into the world motherless. Life is hard enough for children with a mother; how much harder it is

without one! and such catastrophes are very frequent in our land, in which the maternal puerperal mortality is greater than in any other so-called civilized country in the world.

KIDNEY DISEASE

What was said about heart disease is applicable, even if not with the same force, to renal disease. Cases of serious kidney disease are greatly aggravated by pregnancy, and while the woman is not apt to die during labor as is the case in heart disease, a fatal issue is very much hastened.

SYPHILIS

Some say that people who once had syphilis should never marry. This is not so. Syphilis is only dangerous to the married partner when there are open sores or mucous patches. As long as the syphilitic is "clean" externally he may have sex relations, even if his Wassermann is positive, *provided* the wife does not become pregnant. It is through pregnancy that the wife of a syphilitic may become syphilitically infected, and of course the children may also show

the syphilitic taint.—Briefly: a syphilitic who is free from any skin or mucous lesions may marry, but the wife must not become pregnant, both for her own and for the potential child's sake. There are children of once syphilitic parents who seem to be quite healthy, physically and mentally normal; but it is always taking a chance, and whether the parents have the moral right to take the chance, is a question which must be left to them to decide. Perhaps even they have no right to decide, but the medical expert is to decide it for them. I generally say: No!

GONORRHEA

Of course no man worthy of the name will marry or have sex relations in an acute stage of gonorrhea (though we have known such things to happen); but there are cases which are cured or practically so, but in which we still entertain some doubts, and yet for various social or other reasons the marriage must take place as arranged. In such cases, our permission to the marriage may be given, *provided* the wife does not become pregnant. Pregnancy in such

cases may lead to infection of the wife and to ophthalmia neonatorum in the child. Prevenception in such cases is therefore imperative.

TUBERCULOSIS

To impregnate a woman who has active or dormant tuberculosis or healed tuberculous lesions, particularly to cause her to be pregnant repeatedly, is nothing short of *criminal.* It *unquestionably* hastens her death, and the children may show tubercular tendencies. We have known cases where the woman with healed lesions was rapidly brought to her grave because of pregnancy; and on the other hand, we have known couples where both the husband and the wife have been tubercular and, nevertheless, led a happy existence because they employed prevenceptives, and the wife did not become pregnant even once.

NARROW OR DEFORMED PELVIS

We know that there are women who have such narrow or deformed pelves that they cannot possibly give birth to a child in the natural

way. They must undergo Cesarean section. Of course the enlightened opinion is that when a woman who is undergoing Cesarean delivery even the first time asks to be sterilized, her request should be complied with. We have no right to *force* a woman to undergo repeated Cesarean sections. Yet there are physicians (almost invariably Catholics) who refuse to sterilize a woman even when she has undergone several, three, four or five Cesarean sections. In our opinion such a refusal is sheer obscurantist brutality. It goes without saying that where a woman who has risked her life undergoing one or more Cesarean sections, asks for prevenceptive information, it is our bounden duty to give it to her.

FEEBLE-MINDEDNESS, INSANITY, EPILEPSY

Mental abnormalities. While we no longer ascribe to heredity the same significance that we used to formerly, being convinced of the overwhelming importance of environment, using the word in its broadest sense, still there is no question that psychopathic foundations are

inheritable. And while children of feeble-minded, insane or epileptic parents or families *may* be normal, who with a decent sense of responsibility would care to take a chance? There are enough children born daily on this globe of ours without our having to take chances on offspring from definitely tainted stock. And parents in whose families there were *several* instances of feeble-mindedness, insanity or epilepsy should certainly use prevenceptives. Of course, the *insane,* as well as the feeble-minded and morons, whether men or women, should invariably be sterilized.

EXCEPTIONALLY DIFFICULT LABOR

There are cases—what physician has not seen them—where the woman is anatomically normal, and the child can be delivered without Cesarean section, and yet the labor is so difficult, so painful, the shock to the nervous system so severe that she almost dies in the attempt. Forever after the memory of the agony she has undergone terrifies her, and we heard more than one woman say: "I'd rather be dead

than have another baby, to undergo the tortures once more." Such women have a perfect moral right to demand and to receive prevenceptive information.

SPECTER OF REPEATED PREGNANCIES

As we have stated many times before, the worst and most terrifying specter that hovers over the heads of millions of women is the specter of repeated unlimited pregnancies. I am not referring here to difficult labor, etc. No, the labor may be quite easy, but the idea of having to nurse, feed, clothe, educate and bring up another child is a source of deep suffering, fear and nervous disease to a great many women, and men, too. Not only to those of the poor and proletarian classes, but to those of the middle and professional classes as well. Perhaps to the latter two even more than the former, for they have a greater sense of responsibility than they of the "lower" classes. The use of reliable prevenceptives has a remarkably beneficial effect on the health and general nervous condition of these cases. The use of prevencep-

tion has saved many a home from going on the rocks and suffering a complete break-up.

MISCELLANEOUS CONDITIONS

There are a number of miscellaneous conditions with which every physician is familiar which render the use of prevenceptives advisable or imperative. Some women, as we know, suffer during pregnancy from pernicious vomiting so atrociously that their lives become endangered and it becomes necessary to induce an abortion. Others develop life-endangering eclampsia during labor. Still others become insane with each childbirth—puerperal insanity. In all such cases, the use of prevenceptive measures is permissible, advisable and imperative.

POVERTY

And last but most decidedly not least comes poverty. I know that "mere" poverty is not considered a legitimate claim on prevenceptive information, but in my opinion, it is one of the most important reasons—perhaps more important than all other reasons combined—for

birth control. And by poverty I do not mean only that dire wretchedness where actually there is not sufficient food to go around, where the children are most of the time hungry, ragged and crowded in a basement or three room tenement apartment. Only a brutishly medieval mind will refuse prevenceptive information to such mothers. By poverty I mean a condition which makes it impossible to give the children the comfort, the hygienic surroundings, and the education to which the parents aspire and to which they think the children are entitled. The parents are certainly the ones to decide how many children they can and want to have, and when they want to have them. No outsider should have the impudence to try to decide it for them.

CHAPTER III

ONE HUNDRED PER CENT SURE PREVENCEPTIVES

The question is often challengingly thrown at us: Have you any 100 per cent certain methods to offer? The answer is: Yes!—and No! And what we mean by this answer is this: while there is not a single method (except vasectomy and salpingectomy) which is 100 per cent sure and certain in 100 per cent of *all* men and women on the globe, there is not a single method which is not 100 per cent sure and certain in *some* people. In other words, prevenception is and for some time must remain an individual affair. No one method is applicable or recommendable to everybody indiscriminately. Not only must we consider the physical and anatomical condition of the patient, the fact whether she had no children at all, or one, two or more children, but even the patient's social and economic circumstances must be taken into consideration. It would be mani-

festly absurd to recommend the same method to the woman with a luxurious bathroom and the most modern "personal hygiene" accessories and to the woman who had never seen a bathtub in her life (I have met such women in the villages of some of our Western states) and to whom a douche bag is a rare and complicated piece of apparatus. How many times have I met, in letters from poor women, the question—what do you mean by douche and how do you use it? I repeat, the proper use of prevenception or birth control is and must remain for some time an individual problem; i. e. the man or woman must use the method most suitable to his or her case, and, *unfortunately*, this can often be decided only by a physician, particularly by one who has made a special study of the subject of prevenception. And while I consider objectionable, and shall not recommend any method of prevenception that makes a slave of the woman, necessitating her going to the doctor once or twice a month or even three or four times a year, I see no particular misfortune in an urban man or woman

having to go to a doctor once to be instructed in the proper, and most suitable for him or her, methods of birth control. A patient goes to a doctor with a headache or stomachache; to be instructed in the proper methods of birth control, the results of which are so intimately connected with the weal or woe of the family, is surely worth one or two visits to the doctor.

The reliability of the modern prevenceptives can best be seen from a study of the birth rates in various civilized countries. The tremendous fall in the birth rate in all countries in which prevenception is used is so clear and unmistakable that only one mentally blind is unable to see it, and acknowledge the true cause of it.

I stated above that there is no method which is not 100 per cent sure in some people. To make this statement clearer by an example: The douche after intercourse is considered a very uncertain method of prevenception, having about fifty per cent failures to its record. Yet there are thousands and tens of thousands of women who use nothing else but the douche,

and as long as they use it they feel and are perfectly safe; as soon as they deliberately or through negligence or laziness fail to use it, they conceive. In other words, with them the douche *is* an absolute prevenceptive. (Why the douche succeeds in some cases and fails in others will be discussed in the chapter on douches.) The same is true of coitus interruptus, the condom, prevenceptive suppositories, jellies or tablets, the cap or diaphragm pessary, and so forth.

In short, the subject of prevenception demands study, thought and individualization, and the subject is important enough to deserve study, thought and individualization.

To avoid any possible misunderstanding, I wish to make perfectly clear my attitude in reference to the relationship of the physician to prevenception; and at the risk of some repetition, I will state my opinion on the subject.—To be able to limit one's offspring to the number desired, to be able to have as many, or as few, children as we want to have and to have them when we want to have them, is important

enough to justify a visit to a physician. But no prevenceptive will ever gain, or deserves to gain, universal popularity and acceptance, which makes the woman dependent upon the doctor, which forces her to go to him twice a month, before and after the monthly periods—to remove and put back again a pessary, a cap, a key or whatever appliance the woman wears. And even those appliances which may be worn during the menses and which require a visit to the doctor only three or four times a year are objectionable. Some women can't afford, and some women won't go to a doctor several times a year. What is more, millions of women throughout the world live so far away from a doctor that they cannot consult him even once, and, therefore, until the State or private agencies and birth control clinics take the matter in hand, and see to it that every woman *with her marriage license* gets complete detailed instruction in prevenception, the best prevenceptive will be the one which *every* woman can use without a visit to a doctor, merely from a printed leaflet with illustrated instructions.

CHAPTER IV

ARE PREVENCEPTIVES INJURIOUS?

To THE question: are prèvenceptives injurious? the answer is an emphatic No! None of the modern prevenceptives, recommended by responsible birth control advocates, is capable of causing any injury. I have not seen a single case of injury resulting from the modern chemical or mechanical prevenceptive methods, but I have seen a great deal of benefit. So many women, for instance, suffer from leucorrheal discharges and cervical erosions. To them the use of the modern antiseptic jellies, suppositories or tablets is a distinct benefit, moderating and diminishing the former and often curing the latter. That there are injurious and even dangerous prevenceptives, is of course admitted, but we have nothing to do with them and we are not responsible for them. Only the other day a woman was brought to me by her

husband, with an eroded and fearfully inflamed vagina. She had three children in four years and they were searching for some prevenceptive. A fool friend told the husband that the most effective prevenceptive was bichloride of mercury, without giving any explanation of its use. The husband got a tube of bichloride tablets, and before intercourse the wife introduced a whole tablet into the vagina. The result need not be dilated upon. (The husband's glans was also irritated.) To emphasize: The modern prevenceptives are non-injurious, and in many cases demonstrably beneficial. This beneficial action refers to the local utero-vaginal condition. As far as the general benefit is concerned, the benefit to the woman's general health and her psychic condition as a result of the removal of the black fear of another pregnancy, and another and another—this is positively incalculable. Some women are converted into truly new beings when the specter of unlimited pregnancies is removed from their minds, and they become better wives and better mothers.

CHAPTER V

DOES THE USE OF PREVENCEPTIVES CAUSE STERILITY?

Reactionary physicians opposed to birth control under any circumstances try to frighten the people by holding out to them the statement that the use of prevenceptives will make them permanently sterile, so that when for one reason or another—for instance, the death of a child—they will want to have offspring, they will be unable to have their wish realized. The women who must have recourse to the use of prevenceptives, often wish it were so, i. e. that they did become permanently sterile. But, alas, they know that it is not so. For not infrequently, a single omission to use the prevenceptive results in pregnancy!

No, we can conscientiously assert that we do not know of a single case in which the use of the modern prevenceptives has resulted in permanent sterility. It is conceivable that the use

of toxic chemicals, like bichloride of mercury or of *intra-uterine* pessaries may result in an inflammatory condition of the endometrium and the Fallopian tubes with consequent sterility; but *we* are not responsible for that, for we condemn unequivocally the use of both bichloride of mercury and of intra-uterine pessaries.

I therefore summarize: The modern prevenceptives are non-injurious, are, on the contrary, often beneficial, do not cause sterility and are to a high degree dependable. But to the question: Do we now possess the 100 per cent *ideal* prevenceptive, the answer is: No. For an *ideal* prevenceptive should answer the following seven requirements:

(1) It should be *absolutely* certain and infallible. That is, it should accomplish exactly what it is intended to accomplish in one hundred per cent of all cases.

(2) It should be perfectly harmless; it should cause no damage or disagreeable sensation to the man or the woman during or after the act, nor should it injure the health in the long run.

(3) It should cause no inconvenience of any kind.

(4) It should not be unesthetic or disagreeable to use.

(5) It should not diminish the pleasure of the act and it should not interfere with the voluptuous sensation in either the man or the woman.

(6) It should be easily used or applied without any expert instruction. It should not be necessary to have a physician or an expert to teach its application or to insert it or remove it periodically.

(7) It should be cheap. In this country this is not such an important requirement, but still in view of the fact that it is the poor strata of the population that are in the greatest need of prevenception, this condition cannot be altogether neglected.

And at the present time there is no single prevenceptive measure which fulfills *all the seven* conditions. There are prevenceptives that fulfill two, three or more of the above enumerated requirements, but not one that an-

swers every one of them. However the time is coming, it is almost here, when the *ideal* prevenceptive will be *real,* fulfilling all the seven requirements.

CHAPTER VI

THE BASIC PRINCIPLES OF PREVENCEPTION

In spite of woman's great advance in many fields of human activity, in spite of her growing economic and political independence, in order that a child may be conceived, the participation of the man is still necessary; yes, absolutely necessary and indispensable—and this in spite of Jacques Loeb's questionable experiments with some sea urchins referred to by every half-baked amateur dabbler in sexology, in spite of Bernard Shaw's nonsense in *Back to Methuselah,* in spite of Prof. Haldane's far-fetched fantastic excursion into the field of ectogenesis in his *Dædalus.* For conception to take place it is absolutely necessary for the male spermatozoön to come in contact with the female ovum. The female ovum is a passive, immobile cell; the male spermatozoön is, on the contrary, a very active

—sometimes too active—motile little "animal" or cell which runs most energetically after the female ovum. And the whole principle of prevenception or prevention of conception consists in preventing the spermatozoön from entering the uterus and coming in contact with the ovum. All prevenceptives have this aim in view. They either, by their chemical composition, destroy the spermatozoa or render them non-motile, so that they cannot move; or they obstruct, close up the opening of the womb, so that even if alive and motile, the spermatozoa cannot enter it. It will be seen how ignorant, or deliberately misleading are they who confuse prevenception with abortion. In abortion the conception has already taken place; the spermatozoön and the ovum have already met, and an embryo or fetus has resulted; there is already some sort of life, even though it is biologically parasitic in character. In prevenception, we *prevent* the spermatozoa from coming in contact with the ovum, we prevent conception from taking place, consequently there can be no question of destroying life, when life has

not yet commenced. It should not be necessary to dilate upon this point, only misrepresentation and ignorant maliciousness are still rampant, and it is therefore necessary to bring it up and expose it at every proper opportunity.

* * *

Prevenceptive measures are divided into two classes: those used by the man, and those used by the woman. The prevenceptives which may be used by the man are three in number: withdrawal, the condom and vasectomy. And as we will see in discussing every method in detail, none of these is free from objections. The methods used by the woman are numerous, the principal ones being: douches, suppositories, tablets, jellies, the iodine method, cervical caps, diaphragm or Mensinga pessaries, intrauterine appliances, the safe period, nursing, holding back; and, the most radical of all, salpingectomy.

We will now proceed to discuss every method separately, pointing out its advantages and disadvantages, its reliability or non-reliability, and the reason why we approve or condemn it.

CHAPTER VII

COITUS INTERRUPTUS

INTERRUPTED intercourse or withdrawal, also referred to popularly as "taking care" (or as the French term it, defrauding) consists in normal intercourse up to the point of culmination; when the man feels that ejaculation is about to take place, he withdraws the organ and ejaculates into a previously prepared napkin, or on the woman's mons veneris, vulva, abdomen or thighs (some wives have not the slightest objection to the depositing of the semen on some part of their body; quite the contrary). In spite of its many disadvantages which will be discussed further on in this chapter, this method is still the most popular, i. e. the most universally used of all methods, because it involves no cost whatever, requires no preparation or paraphernalia of any sort, and can be used anywhere, at any time. Because

this method, known from most ancient times (didn't Onan use it when he wanted to avoid impregnating his brother's wife?) is used so universally, and because queries as to its desirability, reliability, harmlessness or injuriousness reach the author of this book so frequently, he proposes to discuss it in some detail.

A gentleman, well known in the literary world, while visiting New York, asked for an appointment, as he wished to discuss a subject in which I was deeply interested. The appointment was readily granted. The object of the literary gentleman's visit was to tell me that, in his opinion, all the labor, energy, time and money expended in research work on contraceptives was just wasted; that all the discussions, papers, leaflets and pamphlets on jellies, suppositories, tablets, cap pessaries, diaphragms, etc., were sheer nonsense unless the manufacturers of these articles did it for commercial exploitation, did it just to make money. Here, he has been using a method for twenty years, a method which *costs nothing,* which is

accessible to all, and which is 100 per cent—not 90, 95 or 97 per cent, which is claimed for the best methods—but 100 per cent sure. In all the years he had used it, it has not failed once. The search for and the use of other prevenceptive methods is therefore futile and worse than useless. It is reprehensible because it is misleading. It is reprehensible to make people use expensive and unsafe methods, when a costless and absolutely certain method is within reach of *everybody.* I surmised what this infallible method was, and my surmise proved correct: The ideal method of prevenception used by our literary friend, and which in his opinion rendered all other methods worse than superfluous, was nothing less than coitus interruptus. To the question as to whether he thought the method in any way injured his nervous system or affected his potency, he answered with an emphatic *No.* And one could well believe him, because he appeared in excellent health and spirits, and of course he had no reason to misrepresent the facts. As to his wife, she had not the slightest objection to this method; she al-

ways reached the climax at least once, and sometimes two or three times before he was ready to withdraw. It might be added that when they wanted children—and they have three, three *desired* children—they practiced normal coitus, and conception promptly took place.

Here then, we have a beautifully convincing case in which coitus interruptus has proven the ideal method for twenty years, and will no doubt continue to prove ideal during the entire period of that couple's married life. *And here we also have a striking illustration of the untrained or nonscientifically trained layman's ineradicable tendency to generalize, to judge of all humanity by himself.* Because coitus interruptus has proved ideally satisfactory in his case, he is convinced that it must be satisfactory for everybody and that the search for prevenceptives is futile and unnecessary.

When I told him that I could show him hundreds and hundreds of cases in my own practice and experience in which this method proved unsatisfactory, failing utterly in some (I know

one man who practiced this method religiously and who is now the father of eight—undesired—children), destroying every bit of pleasure in the act in others, causing nervous derangements, impotence and frigidity in still others, he was surprised, but as I could see, not quite convinced. "There must be something wrong with those people," he said. "No, there was nothing wrong with them, except that they were not blessed with the same powerful virility that you are. And you ought to know that people differ *enormously* in this respect. A method of prevenception which may be not only satisfactory but ideal for some, may be worthless, utterly worthless, or non-feasible or impossible of execution for others."

What is the truth about withdrawal or coitus interruptus? In spite of its importance, this subject has never been discussed intelligently, fully, without bias and from *practical* experience with hundreds of cases.

I shall attempt to do so here.

This is the truth about coitus interruptus.

1. For a certain limited number of people

coitus interruptus is the ideally satisfactory method, i. e. it *never* fails, the act is practically as pleasurable to both parties as normal coitus, and it has no deleterious effect on either the man or the woman. The people of whom this is true have the following characteristics: The man is of a non-nervous temperament, is *strongly virile,* capable of "holding in" the semen as long as he wants to; the wife has one or more orgasms before he withdraws, and has herself a copious discharge with the orgasm. Such people may and do practice this method for decades without injury. I have known a couple who continued this method even after the wife had passed her menopause. They got so used to the method that they preferred it to normal coitus. And if all men and women were of the type just described, the entire birth control propaganda and all the research work on prevenceptives *would* be wasted effort indeed. But alas! to the majority of mankind, the advice to use this method is offering a stone instead of bread, and I shall proceed to explain why.

2. Some men practice this method in good faith, withdrawing the organ when it is quite dry—and still find that their wives get pregnant every year or two. Why? Because their closing mechanism is not perfect, the sphincters that hold the semen in do not close as tightly as they should and there is a *leakage* of a drop or two of semen—not enough to be perceived or felt by the man or the woman, but amply sufficient for the act of impregnation. And some men do suffer from real spermatorrhea and are unaware of their condition. Quite some tragedies both in the married and in the unmarried, are due to this little-known fact. The man is perfectly honest in assuring the woman that he withdrew before there was an ejaculation, but the mishap—the pregnancy—points to the contrary, and the woman feels justified in accusing the man of deliberate bad faith or of carelessness.

3. Some men have such a weak sensation during the act that they are *not aware* when ejaculation takes place. If they feel any moisture they think it is from the vaginal secretion,

and they withdraw when it is all, or practically all over. Such people cannot, of course, practice coitus interruptus.

4. Some men do know the moment when the ejaculation is about to take place, but they are in such a state of excitation that try as they may—their will seems paralyzed—they simply *cannot* withdraw in spite of the fact that they are all the time aware of the disastrous consequences of their failure to do so. But I repeat they *cannot,* and so the ejaculation takes place with a resulting pregnancy.

5. Some men have such tremendous will-power that though it is as difficult and as painfully disagreeable for them to withdraw as it is for the people of the preceding class, they do succeed in withdrawing; but it gives them such a "wrench," their nervous system is so shaken that after a while the disastrous results of the practice are unmistakable. It is people of this class who become neurotic, irritable and sometimes profoundly neurasthenic. The pernicious effects on the sexual system may be: a congested prostate, premature ejaculation

(very frequent), weakened erections and loss of or diminished libido. Many men of this type prefer not to have *any sex relations at all* to having coitus interruptus.

6. It is the *inability* to practice coitus interruptus that drives some men to perverse methods of coitus such as *coitus in ore, coitus in ano, coitus intra mammas, coitus in axilla,* etc.

7. So far we have dealt with the lord of creation—man. Now a word about the effect of coitus interruptus on woman. As stated in section 1 of this chapter, some women get along very well with this method. But to a great number of women coitus interruptus is not only distasteful, but distinctly injurious. Many women can experience an orgasm only at the moment of the seminal ejaculation. They must feel the moistening, lubricating effect of the semen. If this does not take place they are unable to reach the desired culminating point, and this leaves them in an unsatisfied, irritable, sleepless condition, with headaches, backaches and a number of other unpleasant symp-

toms. Even the ancients knew that *uterus est animale sperma desiderans*—(the uterus is an animal which craves semen).

8. Some women have very scanty vaginal secretion; at the moment of the orgasm they may have some "emission," or even then it may be very scanty or absent. Where there is no orgasm the vagina remains dry and hot, and the friction without the lubricating effect of the spermatic fluid or the woman's own secretion, may result in vaginal irritation, uterine and ovarian congestion and even inflammation of the adnexa.

9. As a result of the above, many women who are forced to undergo coitus interruptus acquire a *disgust* for sexual relations altogether and become frigid. The frigidity is an artificial one, and the results of it are not happy ones. While a woman who is congenitally frigid does not suffer because of it—except mentally or in her imagination so to say—a woman who has *acquired* frigidity because of unfavorable circumstances, as a defense mechanism, *does* suffer because of it; and the only

remedy for it is the giving up of coitus interruptus, and practicing normal coitus.

10. It is because of the disadvantages and the impossibility of practicing the method successfully, described in sections 2 to 9 inclusive, of this chapter, that coitus interruptus is not a universally acceptable and satisfactory method, and as a consequence, the search for better and better, more universally applicable methods is not futile or superfluous.

To summarize: Coitus interruptus is a satisfactory, non-injurious and reliable prevenceptive method for a very limited number of people. It is an unsatisfactory method, because disagreeable, unreliable and injurious for the vast majority of men and women of all civilized countries.

Some men and women consider coitus interruptus so nasty and obnoxious that they feel a nauseating disgust at the very mention or thought of it.

(What effect it may have on savages or primitive races, assuming that they know enough to practice it, I do not know.)

P. S. While fully recognizing the injurious effect of coitus interruptus on many men and women, I do not go to the extremes of some of the older physicians, some of whom have claimed, for instance, that this method, per se, may be the cause of cancer of the womb. There is not a scintilla of evidence of any relationship between the two—no more than there is between cancer of the uterus and the use of modern prevenceptives—a relationship also claimed by some old fogy doctors opposed to birth control.

CHAPTER VIII

COITUS SINE EJACULATIONE

WITHDRAWAL, and long protracted intercourse (coitus protractus) are bad enough for the nervous system. There is still another, more "refined" method in which the act is made to last for hours and without any ejaculation. By long practice a few men can learn the trick. It is the method known under various names, Karezza, Diana, Zugassent's Discovery, male continence, etc., and was in use in the well-known Oneida Community. The human machine is built peculiarly, and a few human specimens can learn almost anything. Aren't there men who can learn to hold their breath for minutes at a time? In spite of the fact that there are a few warm admirers of this method,—some are filled with an enthusiasm for it which borders on religious or insane fanaticism—I condemn it unequivocally. It is an insane method, the

idea of which could have originated only in abnormal minds. I know I shall get letters chiding me for this statement in no uncertain terms, but I cannot change my opinion on the subject. Every act of intercourse should lead to an ejaculation, and preferably within the vaginal canal. Every other method is abnormal. Tumescence must be followed by detumescence. Otherwise you are sure to have congestions and inflammations of all sorts.—And so, coitus reservatus, or incompletus, or intercourse without ejaculation, is no feasible method of birth control. It is as bad as withdrawal—only many times worse. And this with all due respect to the devotees of the Karezza, Diana or Oneida methods whose sincerity and truthfulness I do not doubt. But what may be acceptable to and feasible for one person out of ten thousand cannot be recommended to the other nine thousand, nine hundred and ninety-nine who consider the method impossible and on whom the mere attempt exerts a most pernicious effect.

That the Karezza idea did not originate in

normal minds but in minds clouded by vague mysticism will be clearly seen by anybody who would take the trouble to peruse the little book *Karezza* by Dr. Alice B. Stockham, one of the principal protagonists of the method. The participants in the frustrated sex act are advised to keep away their thoughts from merely physical sensations but to concentrate their minds on high and noble devotional things. In this manner, ejaculation will be prevented, but they will be raised to a higher plane. To show the absurdity of the whole thing, it may be worth while to reproduce verbatim Dr. Stockham's explanation of that sublime, spiritual method of intercourse.

> Karezza so consummates marriage that through the power of will, and loving thoughts, the crisis is not reached, but a complete control by both husband and wife is maintained throughout the entire relation, a conscious conservation of creative energy.
>
> The law of Karezza dictates thoughtful

preparation, even for several days previous to the union. Lover-like attentions and kindly acts prophesy love's appointed consummation. These bind heart to heart and soul to soul. There should be a course of training to exalt the spiritual and subordinate the physical. This is accomplished through reading and meditation. The reading should lead to exaltation of spirit, and to the knowledge of the power and source of life. The authors chosen should be illuminated souls such as Browning, Emerson, Carpenter. It is not easy to advise for individual cases. W. F. Evans, Henry Wood, and R. W. Trine have revealed the law of spirit and given practical helps in life's adjustment.

The meditation should be an act of giving up of one's will, one's intellectual concepts, to allow free usurpation of kosmic intelligence. In obedience to law, common or finite consciousness listens to kosmic consciousness. Daily, hourly, the listening soul awakens to new ideals.

Coitus Sine Ejaculatione

At the appointed time, without fatigue of body or unrest of mind, accompany general bodily contact with expressions of endearment and affection, followed by the complete but quiet union of the sexual organs. During a lengthy period of perfect control the whole being of each is merged into the other, and an exquisite exaltation experienced. This may be accompanied by a quiet motion, entirely under subordination of the will, so that the thrill of passion for either may not be beyond a pleasurable exchange. Unless procreation is desired, let the final propagative orgasm be entirely avoided.

With abundant time and mutual reciprocity the interchange becomes satisfactory and complete without emission or crisis. In the course of an hour the physical exaltation increases, and not uncommonly visions of a transcendent life are seen and consciousness of new powers experienced.

Before and during the time there may

be some devotional exercises, or there may be a formula of consecration of an uplifting character in which both unite. This aids in concentration and in removing the thoughts from merely physical sensations. The following has been helpful to many: "We are living spiritual beings; our bodies symbolize soul union, and in closest contact each receives strength to be more to the other and more to all the world."

As to the frequency with which this insane method of intercourse may be performed, the author tells us that "experience has proven that it is far more satisfactory to have at least an interval of two to four weeks, and many find that even *three or four months* afford greater impetus to power and growth as well as more personal satisfaction." The author, anticipating the objection that such intervals may be too long, says: "According to the law of Karezza, *the demand for physical expression is less frequent* (these italics are the author's own, not mine), for there is a deep soul

anion that is replete with satisfaction and is lasting." I can well believe that according to the "law" of Karezza the demand for physical expression, i. e. for sexual intercourse, becomes less frequent. For that sort of intercourse not only once in four months, once in four years would be sufficient.

CHAPTER IX

COITUS CONDOMATUS

NEXT to coitus interruptus or withdrawal, coitus condomatus or intercourse by the aid of a condom is the most widely used method of prevenception. The condom was invented by Dr. Condom with no idea of being used as a prevenceptive. He suggested it as a method for prevention of venereal disease at a time when gonorrhea and syphilis, particularly the latter, were raging in Europe. And as a venereal prophylactic the condom has rendered great service to humanity and I agree with Prof. Blaschko that the unknown and forgotten Dr. Condom, if he was the inventor,* deserves a monument as one of mankind's benefactors

*Some deny that Dr. Condom was the inventor of the condom. They deny even the existence of a Dr. Condom, claiming that it was the great anatomist Fallopius, after whom the Fallopian tubes are named, who first suggested the use of a protecting sheath.

(much more so than do the wholesale killers). It is only much later that it dawned upon us that an appliance that would keep the venereal germ from getting into or unto the male organ would also prevent the spermatozoa from getting into the uterus.

The condom, also called sheath, protector, French letter or, vulgarly, overcoat, has been made of various materials, but is now made exclusively either of animal membrane or rubber. The animal membrane or cecal condom ("fishskin" or goldbeater's skin) made of the cecum of sheep, decreases the pleasurable sensation during intercourse *less* than does the vegetable rubber condom. But the former has the disadvantage that it has to be moistened before use, and it is somewhat more apt to slip off. The rubber condom holds more firmly by its own elasticity, is pleasanter to use, but, as stated, dulls the pleasurable sensation more than does the cecal condom. Whichever kind is used, a suitable size should be selected. It is absurd to use the same size condom on all male organs, which differ in size, either when flaccid

or erect, as one to two, three, four or even five. If too large a size is used, it is very apt to slip off; if too small a size, it is apt to constrict the organ and to break during the act. The man should therefore specify whether he wants a small, medium or large size.

While coitus interruptus is used among all classes, the condom is not much in use among the poorer classes or proletarian masses, and the principal reason is the *cost*. The worker cannot afford to spend twenty-five to fifty cents —the cost of a condom in this country—each time he has relations with his wife.

However, with a little care and trouble, a condom, either skin or rubber, can be used several times.

A well-fitting condom of good quality is one of the safest, i. e. most reliable, most dependable methods at our command. And it does not require the services of a physician, as the pessaries, whether cap or Mensinga type, do. This being the case, where is the trouble? Why look for other prevenceptives? Why not limit ourselves to the advocacy of the use of condoms,

as is in fact done by some European gynecologists and social hygienists?

Unfortunately, the condom possesses certain disadvantages, which we will proceed to enumerate here, and which will show clearly why it cannot be advised as, and why it can never become, the universal method.

1. First of all, it diminishes considerably the pleasurable sensation, the voluptuous feeling obtained from the contact of the male organ with the vaginal wall. Now, in some men the voluptas is so great, the pleasurable sensation from the contact is so intense, that the intervening skin or rubber tissue of the condom is not sufficient appreciably to dull or diminish it. The pleasurable feeling of the entire act is so intense that the condom has no unfavorable effect on it. Such men can go on for years using the condom without any complaint, and to them the condom is a perfectly satisfactory method.

2. Unfortunately, the voluptas of the act is in a great number of men but moderate or even mediocre; and the use of the condom seems to

take away every bit of pleasurable sensation or enjoyment. Many men told me that they derive greater pleasure from a masturbatory act than from coitus condomatus, and that they would rather renounce intercourse altogether than to be condemned to perform it with a condom for the rest of their lives. And this is the primary and most frequent complaint against the condom: it takes away all pleasure from the act.

3. There are men, not exactly impotent, but of weak sexuality. Their erections are feeble, yet sufficient for normal intercourse. But as soon as they begin to put on the condom, the erection subsides; and in some cases, trying to pull on the condom is in itself sufficient to cause an ejaculation; the member becomes flaccid, and the act cannot be accomplished at all, to the great discomfiture of the husband, and the expectant but disappointed wife.

4. Now and then the method fails, for various reasons which are as follows: a) The condom slips off. b) It ruptures, which occasionally happens when it is tight or when the act is

performed violently. c) Now and then there is a little hole or a patched hole in the condom which permits the spermatozoa to "wriggle" through. d) Now and then, particularly when the condom is tightly pulled on so that there is no space for the semen between the glans and the bottom of the condom, the semen (a few drops are sufficient) works through the top or the rim of the condom and impregnation results.

5. Now as to the effect of the condom on the woman. Some women apparently do not mind the condom at all. At least they never complain or object to it. These are women whose husbands are virile, so that they can have their orgasms normally during the act—once or even more than once—who have sufficient vaginal secretion, and who during the orgasm secrete abundantly. To such women the condom does not seem to offer any barrier to the normal enjoyment of the act. To others, however, the condom is an abomination and anathema. As I explained in the chapter on coitus interruptus, some women cannot reach the orgasm, no mat-

ter how long the friction may continue, until they feel the moistening, lubricating impact of the ejaculated semen. Such women become highly irritated during coitus condomatus, and in a sort of frenzied state of high excitation, they pull off the condom from the man's organ, even though they are aware that the penalty may be pregnancy. So unsatisfying and disagreeable is coitus condomatus to some women that they refuse to have intercourse altogether rather than to have it with a condom. And as is the case with male withdrawal and "holding back," some women become frigid because of it, but the frigidity is generally temporary, disappearing when coitus condomatus is given up.

* * *

Each and every condom should before the act be blown up with air, by the mouth, or filled with water. The least little hole will then be detected; and of course, if present, the condom should be discarded. Some dishonest manufacturers, instead of throwing away defective condoms with little holes in them, paste on a

little patch; this patch during intercourse is apt to come off, and of course the condom then offers no protection. One must guard therefore against imperfect condoms and purchase only the best varieties from reliable houses.

When the condom is pulled on it should never be pulled to the very end, but a little space should be left for the semen; otherwise either the condom may burst, or the semen may gradually work out through the top of the condom.

Where expense is a consideration, the condom may be used several times. When removed from the penis, it is washed with water, then dipped in an antiseptic solution (bichloride 1 to 1000, lysol), dried, powdered with a little talcum and kept in a well closed box or glass jar.

Where the vaginal secretion is scanty, where the vagina is hot and dry, a little lubricant should always be put on the outside of the condom. But never use vaseline, cold cream or oil on a rubber condom, for fats rot rubber. Use a little glycerin jelly, or one of the prevencep-

tive jellies, the formulas for which are given further on, in the chapter on Jellies.

To summarize: The condom is not injurious per se. If injurious at all, it is certainly much less so than withdrawal. It is simply an unsatisfactory method, because it diminishes the pleasurable sensation of the act—abolishing it altogether in men of weak sexuality. Some women detest it much more than the men do. If intelligently used it is one of the safest prevenceptives. Its great popularity in extramarital intercourse resides in its original purpose as a prophylactic against venereal infection.

CHAPTER X

VASECTOMY AND VASO-LIGATION

As we know the vasa deferentia are the two delicate tubes or ducts through which the testicular secretion passes into the seminal vesicles and the male urethra, thence to be discharged exteriorly or into the female genital canal. If we constrict or block the lumen of the ducts, the testicular secretion naturally cannot pass out, and absolute sterility is the result. If we merely tie the duct with a ligature, vaso-ligation (the Steinach operation), the ligature may be absorbed and the patency of the duct may be spontaneously restored. The operation of vasectomy, on the other hand, is permanent in its results and is therefore preferred.

Briefly, vasectomy is the operation of cutting away a piece of the vas deferens, and ligating the cut ends. When referring to vasec-

tomy for prevenceptive purpose we naturally refer to vasectomy on both sides, for as there are two testicles, there are two vasa deferentia, and to perform vasectomy on only one vas would be a wasted operation, for the spermatozoa would pass out through the other vas.

The operation is a minor one, is not accompanied with danger, is performed under local anesthesia and does not weaken the sexual power. Some even claim that it increases it—are not miraculous results claimed for the Steinach operation, and the Steinach operation, or vaso-ligation, is essentially the same as vasectomy. Because of all this, vasectomy is becoming quite popular among the intelligentsia. It is simple and it does away forever with withdrawal or condoms on the man's part and with pessaries, caps, jellies, tablets, suppositories, douches, etc., etc., on the woman's part.

It would be indeed an ideal procedure—if, when desired, *it could be undone*. But, alas, it cannot. The sterility caused by vasectomy is permanent, forever, as long as life lasts (I will

discuss this point further on), and for this reason when a man comes to consult me on the advisability of having himself vasectomized, I tell him to think it over, to think twice, and then to think again. For one can never know. At a certain time one may be sure that he wants a vasectomy, that he wants no children or no more children; in five or ten years, conditions may be entirely changed and that man and his wife would give anything in the world to be able to have a child. I know the case of a couple, both given to intellectual pursuits; they had one daughter and did not care to have any more children. They disliked the waste of time and trouble involved in the use of the usual prevenceptives, especially because they were traveling frequently, and so he, with the wife's consent, had himself vasectomized. Acute nephritis following scarlet fever carried off the daughter; and it is now, and it will be their eternal regret that they cannot have another child.

I know the case of a young bachelor, somewhat of a roué, who had himself vasectomized

in order to increase his popularity with the young girls. And it did. The absolute assurance that he could give them that nothing could ever "happen" to them was a powerful argument. But even roués change and fall in love sometimes. This one did. But the young lady on whom his passion was concentrated would have none of him, for in one respect at least she was old-fashioned. She wanted to be able to press to her breast a baby or two of her own.

I am often asked how vasectomy affects the sexual power and secretion. As to the power, I have already stated that it does not seem ever to affect it unfavorably; on the contrary, it seems to increase the power of erection and the duration of the act. But even the quantity of the discharged "semen," which of course consists only of secretion from the prostate, seminal vesicles and Cowper's glands, does not seem to be appreciably diminished. With the blocking of the passages from the testicles, there is evidently some overcompensatory activity on the part of the other glands. I was careful to make inquiries on that point from

vasectomized patients and correspondents, and their answers were unanimous in the sense outlined above. But the operation has not been in vogue long enough to entitle us to a definitive, dogmatic verdict.

ARE THE RESULTS OF VASECTOMY IRREVOCABLE?

I stated that the sterility induced by vasectomy is permanent and irrevocable. And I repeat it. I know all about the operation for the restoration of the patency of the duct. I even reproduced literatim the operation devised by Dr. Edward Martin for this purpose in my "Treatment of Sexual Impotence and other Sexual Disorders in Men and Women." I also am aware that in reply to a query by a correspondent, the Journal of the American Medical Association stated that "The restoration of the patency of an occluded vas deferens has been successfully accomplished and reported by many surgeons during the last twenty years." And I do not deny the *theoretical* possibility of such a fortunate outcome; but I do say that practically it is all bosh. *Once vasec-*

tomized, forever sterile. I have yet to see with my own eyes a *single* case of a vasectomized person whose patency of the vasa deferentia was restored, who passed motile spermatozoa and succeeded in impregnating a woman. I have seen several people—two vasectomized and four or five with gonorrheal obliteration of the epidydimides—who paid high fees to surgeons for the restoration of their fertility, but not in a single one was the operation followed by a successful issue. It is unfair therefore to delude the patients with false hopes. And we must present to the candidates for vasectomy or those already vasectomized the sentence which I underlined above, and which I underline again: *once vasectomized, forever sterile.* That despite its irrevocableness vasectomy is a perfectly justifiable and advisable operation in many cases, goes without saying; and I have myself advised it in a number of cases. All I insist upon is that the man, or the man and his wife, if he is married, agree to the operation with their eyes open and with a full realization of its irrevocableness.

Vasectomy and Vaso-Ligation

As I am finishing this chapter, there arrives the book *Sterilization for Human Betterment* by Gosney and Popenoe. The authors have made a thorough, painstaking, scientific investigation of the effects of sterilization—vasectomy and salpingectomy—on men and women, insane, feeble-minded and normal, and their conclusions fully coincide with mine. The insane and the feeble-minded do not interest us in this volume, but the report of the effects on normal people is worth reproducing. The authors have collected the detailed statements from sixty-five men who have been sterilized in private practice.

> These men are for the most part of a high type of intelligence, largely professional or business men; they were sterilized in most instances not because of any physical or mental defect of their own, nor because of sexual debility, but merely to prevent future pregnancies of their wives; hence their evidence is as nearly ideal as could be found.

These men ranged in age from eighteen to seventy at the time of the operation, the average being nearly forty-two. The time that had elapsed since the operation, when they made their reports, ranged from a few months up to twenty years, the average being more than five years.

Merely because of their age, then, some of them might begin to find a lessening of sexual activity. But only two state that they noticed a definite decrease in virility following the operation, and neither of these decreases was great. One of these men feels well satisfied with the operation: the other, who regrets it, is shown by his history to be a definitely abnormal individual, and his case may fairly be excluded for that reason. If so, there remains but one man out of sixty-four who thinks that he is less highly sexed than before the operation, while nine state that they have been more highly sexed since the operation. The remaining fifty-four say that the operation made no change whatever in them.

As to the amount of fluid ejaculated, their testimony also corroborates my statement.

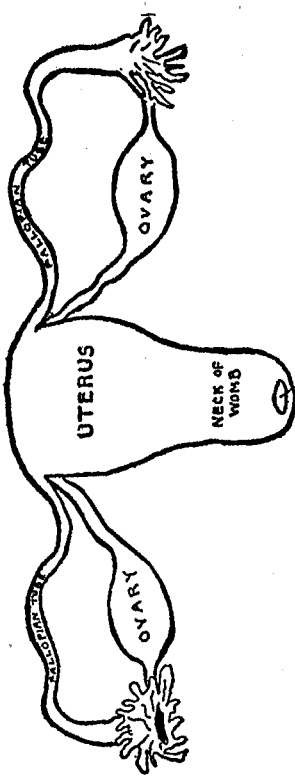
Their report on the effects of sterilization on women will be referred to in the chapter on Salpingectomy.

CHAPTER XI

WOMEN'S PREVENCEPTIVES

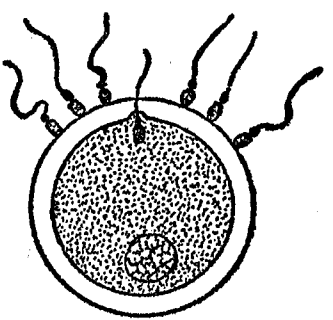
ALL THE measures and methods we are about to describe now belong to the woman's domain. The woman alone can employ them and she is to be instructed in their proper and intelligent use. As I shall have occasion to remark again and again, the failure of prevenceptive measures is frequently not due to the measures themselves but to their unintelligent use. And the reason intelligent women generally have better success with the use of prevenceptives than women from the unintelligent or proletarian masses resides just in this thing: intelligence.

And in general there would be fewer complaints about prevenceptive failures, if every woman were given a ten or five minute lesson in the anatomy of her sex organs. By the aid of a manikin, chart or even simple drawing,



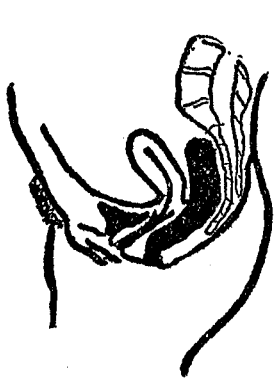
INTERNAL FEMALE SEX ORGANS.

she can be shown the shape and position of the uterus, explained where the os uteri is and that it, or mouth of the womb, is the crux of the whole matter. She can be shown what is meant by retroversion and anteversion, and she can be easily taught, unless she is very fat and has pudgy hands and fingers, to *feel* the cervix.

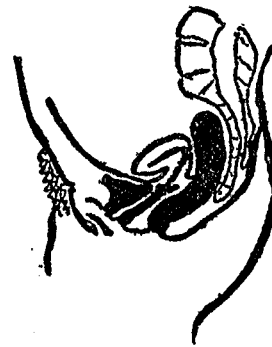


SPERMATOZOÖN PENETRATING THE OVUM.

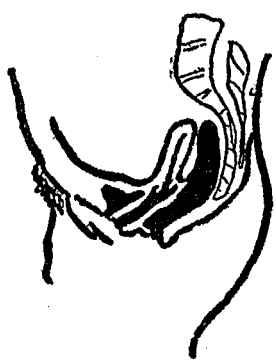
With this little preliminary lesson, every woman will have great success in the use of prevenceptives. Of course, when a woman cannot afford to go to a physician, and has no woman friend familiar with anatomy, she has to dig out that knowledge for herself, from illustrated books.



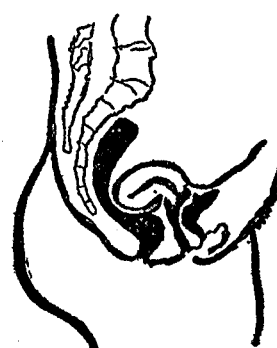
ANTEVERSION OF THE UTERUS.



ANTEFLEXION OF THE UTERUS.



RETROVERSION OF THE UTERUS.



RETROFLEXION OF THE UTERUS.

The vital point every woman is to have engraved on her mind is that whatever she uses, be it suppository, jelly or tablet, it is to be deposited *at* the mouth of the womb, *at* the *os uteri,* or as near it as possible. And if the uterus is retroverted, as it generally is, and if, as in some cases it does, it rests firmly on the recto-vaginal wall, it is rather futile to expect success if the prevenceptive is deposited in the anterior fornix or the vesico-vaginal wall. And the same vice versa—when the cervix is so tipped forward that it points almost to the umbilicus.

CAUSES OF FAILURE

At one time I would give each woman patient who would request and receive prevenceptive information, a little leaflet entitled "Causes of Failure." It used to have a good effect, and I think it worth while to reproduce it here.

Why is it that one woman will use a prevenceptive for years with never a failure, while the same prevenceptive in the hands of another woman will prove a snare and a delusion, mocking at all her efforts to prevencept? I

know two sisters whom we may call Mrs. A. and Mrs. B. Mrs. A. had two children and did not want any more, for several years at least. She was advised to use certain prevenceptive suppositories. During the six years she has been using them, she was not "caught" once. Her sister, two years her senior, also began to use the same suppositories, and within a period of six years she had two—undesired—children, besides one artificially induced abortion. Why this difference? Because—and what I say about the suppositories applies to all other prevenceptives—there is nothing in the world that is fool-proof, and the best and most effective prevenceptive is apt to fail if you do not mix it with a little of that priceless ingredient—brains. I investigated the factors of success in the one and the factors of failure in the other. Mrs. A. was an intelligent woman and, besides, she was instructed by her physician. She understood that the suppository to be effective must be given time to dissolve, that an undissolved suppository is of little value. Besides she was shown on a chart the structure

of the female genitals, the configuration of the uterus, with the cervix. She grasped that it is the mouth of the womb, the *os uteri*, that is the citadel to be attacked, or let us say defended, against the entrance of the enemy. She was shown how to introduce the suppository and where to deposit it. And she proved an apt pupil. She always pushed the suppository towards and deposited it against the cervix; she allowed it to dissolve there before having intercourse, so that the cervix was practically bathed in and covered with a layer of an antiseptic ointment, and under such circumstances conception could never take place. The sister, Mrs. B., perhaps because less intelligent or not properly instructed, would push in the suppository any which way. Sometimes she would deposit it in the anterior fornix, sometimes the posterior, sometimes to one side, so that it would not come near the cervix at all; and besides she would use it immediately before intercourse, so the suppository would not have a chance to dissolve. Under such circumstances, there is no wonder that the suppositories were not effec-

tive. It was not the suppositories, it was Mrs. B. that was ineffective.

And I repeat, this applies to all other prevenceptives. Not always does the cause of the failure lie in the prevenceptives themselves: only too often it is to be found in the users thereof—their unintelligence, carelessness, laziness, utter failure to follow instructions.

I have not the slightest doubt that the time will come when intelligent knowledge of prevenception will become a part of the routine accomplishment of every educated woman—it may be taught in female colleges—and that with every marriage license the couple will be handed a brochure giving explicit and illustrated information on venereal prophylaxis, prevenception and prenatal hygiene.

One other point. A minor point, but one which one must bear in mind. Now and then a woman comes to you, and complains that she has used so and so, and nevertheless she was "caught." On gently investigating, the good lady in question will casually, sometimes nonchalantly, sometimes shamefacedly confess,

that just once or twice she failed to use the prevenceptive. "Just that once." They were out of it, and they didn't think that just once would make much difference. But, my good lady, *when one gets pregnant, one always gets pregnant from one intercourse,* not from two or half a dozen. It is the same as with the use of venereal prophylactics. A man will use them for a year or two. For some reason or other he will omit their use once or twice—and in that once or twice he may just get infected. It is not the fault of the venereal prophylactics.

CHAPTER XII

DOUCHES

DOUCHES belong to the least reliable of our preventeptives. It can be safely said that they fail in at least fifty per cent of all cases. Yet their popularity is undiminished. Why? Because in *many* cases they *are* 100 per cent sure. That is, many women go through their entire childbearing period with the douche as their sole preventeptive, and it never fails them. And seeing its unfailing certainty they recommend it to others.

Why is it that the douche is so certain in some cases and such a failure in others? The reason is very simple. The antiseptic douche would be 100 per cent sure in all cases but for the fact that now and then in the copulative act the semen is ejected directly into, or is aspirated by, the cervix; and once the semen is in the cervix or beyond the external os, no

douche, no matter how powerful, can be of any use. Because the douche only affects the contents of the vaginal canal and does not penetrate into the uterus.

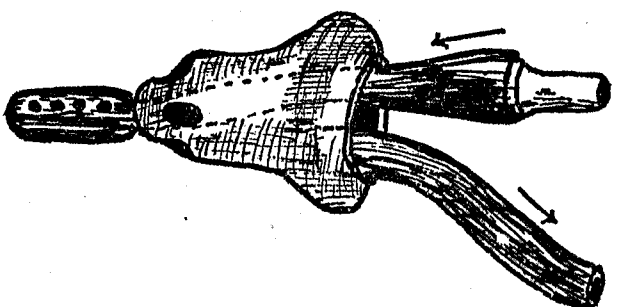
The douche will always enjoy a certain amount of popularity, because it is at the same time a part of civilized woman's intimate toilet, used for purposes of general hygiene and cleanliness. That the use of the douche for cleansing purposes can be and is being overdone is a fact known to many physicians. The too frequent use of douches is injurious because it destroys the natural flora of the vagina; and it is *not* a good thing to remove every bit of secretion from the vaginal mucous membrane. But I am saying this merely *en passant,* as it does not belong strictly within the scope of this volume.

WHAT TO USE IN THE DOUCHE

It is not the strength of the antiseptic as much as the proper method of douching that is important. The spermatozoa are delicate organisms and the mildest antiseptic is sufficient

to render them inert, *if* it reaches them. If one could be sure that the douche reaches every vaginal fold as well as the mouth of the womb, it would not matter what mild antiseptic we use. Even plain water renders them inert, yet plain water is not advisable, because some may escape its action, and some, after having lost their motility, may revive. So the use of an antiseptic is indicated. No toxic substances, such as bichloride or carbolic acid! Vinegar, alum, formaldehyde, boric acid, chinosol, peroxide of hydrogen, solution of sodium hypochlorite, are efficient and harmless. The douche bag usually contains two quarts, and to this amount of water may be added 2 ounces (5 or 6 tablespoonfuls) of vinegar, a heaping tablespoonful of alum, 2 tablespoonfuls of boric (boracic) acid, ½ gram tablet of chinosol, 4 ounces of peroxide of hydrogen, 4 tablespoonfuls of sodium hypochlorite solution. No injury from any of these solutions need be feared. Common salt, 4 tablespoonfuls to two quarts, also makes a good solution. Potassium permanganate (permanganate of potash or simply permanganate)

is an excellent, that is, most efficient spermaticide, yet it must be altogether taboo, because of its staining properties. It is apt to stain and discolor the underwear, the sheets, etc. And people do not want any telltale marks of their use of prevenceptives. The same remarks are applicable to tincture of iodine, and sulphate of



DOUBLE CURRENT VAGINAL NOZZLE.

copper (blue vitriol), both of which are excellent spermaticides.

As to the kind of douche syringe used, bag, bulb (so-called Davidson) or whirling syringe, the difference is not great. The so-called whirling spray is good, but the mistake women make is that they use only one syringeful. That is not sufficient. The syringe should be refilled

and emptied two or still better three times. For the douche bags there are special nozzles now which occlude the vagina, so that the canal can be dilated and thoroughly filled with antiseptic fluid before it is let out. There are also double current nozzles, which while they do not occlude the vagina entirely, have the outlet tube of a smaller diameter than the inlet tube; the vagina can thus be more thoroughly filled and washed out than can be done with the ordinary one-current nozzles.

Until now I spoke of douches post coitum, because this is the manner in which they are almost universally used. *But* there would be far fewer failures on the ledger of douches if they were used, in small amounts at least, ante coitum. And some women have found it out. They carry with them or have handy a half ounce glass syringe, ready filled, with the antiseptic solution in a screw top wooden *étui* or case, and they claim that this *preliminary* injection is 100 per cent reliable, and makes any other injection superfluous, though a regular douche after coitus is advisable as making for

additional safety. And many women are now learning to use a small vaginal injection before intercourse with very gratifying results.

CHAPTER XIII

SUPPOSITORIES

SUPPOSITORIES were the first forms in which modern chemical prevenceptives were used. Rectal suppositories had long been in use in medicine and the thought lay near to use cacao butter as a base or vehicle for introducing antiseptics into the vagina—in a convenient form. And, finding ointments unsatisfactory, I made my first prevenceptive formula in the form of suppositories. Both the jelly base and the collapsible tube were only in slight use when I started my prevenceptive work.—Suppositories are certainly convenient, as convenient as tablets, and more convenient to use than jellies; they also occupy less space than the latter. And no skill is necessary for their use; every woman, however ignorant or obese, can introduce a suppository. Unfortunately the

percentage of failure with them is higher than with jellies or effervescent tablets. Sometimes it is due, it is true, not to the suppositories themselves, but to the ignorant or careless use of them; the people will have intercourse immediately after introduction, before the suppository has had a chance to dissolve; often the woman will push it into one corner of the fornix instead of placing it in front of the cervix. But sometimes the suppository itself is at fault: it hardens and fails to dissolve for a considerable time. Then some people dislike the greasy feel of the melted cacao butter and its odor. When some of it runs out, as it is apt to do in women who have borne children and have a torn perineum, it stains the linen and the bed sheets. And some men with a very sensitive skin get an irritation of the penis from the cacao butter and other ingredients.—But this is true of other forms of prevenceptives as well: the mildest prevenceptive jelly may cause an irritation, especially around the prepuce and glans in some men. Those who are circumcised complain much more rarely.—The

gelatin-glycerin suppository, which obviates some of the objections to the cacao butter suppository, is not satisfactory. I, at least, do not recommend it, and my reasons for this are given at the end of the chapter.

FORMULAS FOR SUPPOSITORIES.

I.
Boric Acid	0.6
Salicylic Acid	0.12
Quinine Bisulphate	0.2
Resorcin	0.06
Oil of Theobroma	5.0

For one suppository.

II.
Quinine Sulphate	0.2
Boric Acid	0.5
Chinosol	0.12
Oil of Theobroma	5.0

For one suppository.

III.
Chinosol	0.1
Quinine Sulphate	0.3
Tannic Acid	0.2
Alum	0.2
Oil of Theobroma	5.0

For one suppository.

IV.
Paraform (Trioxymethylene)	0.15
Oil of Theobroma	2.0

For one suppository.

About the spermaticidal properties of the above suppositories there is no question. If the melted mass is only brought into intimate contact with the ejaculated semen, prevenception is assured. The only trouble is, as explained elsewhere, that some of the semen may escape contact. Most of those who use suppositories prefer the first and second formulas. The third is too astringent, that is, contracts the vagina, but is preferred by women with relaxed vaginas, as well as by their husbands.

I am giving no formulas for gelatin suppositories for I consider them objectionable. They have a tendency to harden and become insoluble, so that suppositories introduced in the evening may come out the following morning practically unchanged; just slightly softened but not dissolved; and in general it takes them too long to dissolve, so that intercourse is apt to take place before solution has been effected, with the object of the suppository—prevenception—utterly defeated. Another point: while every druggist can easily and quickly make up a cacao butter suppository, few are equipped

to make up a decent one with gelatin-glycerin as the base.

Suppositories containing or generating chlorine have recently made their appearance in the market. Perfect efficiency is claimed for them. I haven't had enough experience with them to pronounce a definite judgment. While apparently efficient I heard complaints to the effect that they are irritating.

CHAPTER XIV

TABLETS

From the point of view of convenience, tablets are entitled to the first place. They occupy practically no space, a tube of them can be carried in the vest pocket or in the vanity case, they require no apparatus, their introduction is easy and simple, there is nothing unesthetic about them, and they are not "messy," as most jellies and suppositories are. And if they were as safe and reliable as they are simple and convenient, we would not have to search for other prevenceptives. But they are not. The old time tablet was beneath criticism. It was often so hard that not only would it not dissolve in the vagina, it would not even disintegrate, and the next morning on taking a douche, it would sometimes come away almost whole. On the other hand, it would sometimes be so friable

that it would break into powder in the container or on being removed from it, and before introduction; some would be deliquescent. Some were violently toxic. It seems inconceivable that a man who has the right to call himself doctor would advise a woman to use bichloride of mercury tablets as a prevenceptive. But one at least did; and some women *still use them,* either in a douche or inserted whole! As I mentioned elsewhere, only recently I had to treat a young woman for a severe erosive vaginitis caused by bichloride tablets which she used on the advice of a friend! They are efficient, all right, but at the risk of the poor woman's health and very life.—But such inefficient or toxic tablets are, or are becoming, a thing of the past. The modern prevenceptive tablet is a superior product, as a rule, disintegrates and dissolves readily, and is quite efficient. This is particularly true of the *effervescent* tablet, and this is the only kind that should be used. On coming in contact with water, moisture or the vaginal secretion, the tablet effervesces, liberating a gas which fills

and perhaps distends the vaginal canal; this gas is not favorable to the motility of the spermatozoa, and besides it carries (theoretically) the antiseptic to all the vaginal folds and into the cervical canal. After the effervescence is completed, a thick viscid foam is left which acts as a chemical and mechanical prevenceptive.

The effervescence and the generation of gas is effected by one of two methods: either by the use of an acid and a bicarbonate, or by the use of sodium perborate. Where we use, say, tartaric acid and sodium bicarbonate (the two substances usually employed) decomposition takes place, in the presence of moisture, with the generation of carbon dioxide, CO_2.

$2NaHCO_3$	$+$	$H_2C_4H_4O_6$	$=$	$Na_2C_4H_4O_6$	$+$	$2CO_2$	$+$	$2H_2O$
sod. bicarb.		tartaric acid		sodium tartrate		carbon dioxide		water

When sodium perborate is used, the substance formed is hydrogen dioxide or peroxide of hydrogen, which in contact with organic matter yields oxygen.

$$\underset{\text{sodium perborate}}{NaBO_3} + \underset{\text{water}}{H_2O} = \underset{\text{sodium metaborate}}{NaBO_2} + \underset{\text{hydrogen peroxide}}{H_2O_2}$$

$$\underset{\text{hydrogen peroxide}}{2H_2O_2} + \text{organic matter} = \underset{\text{water}}{2H_2O} + \underset{\text{oxygen}}{O_2}$$

A very efficient tablet is one containing as its principal ingredient dichlorylsulphamido benzoate which on decomposition yields nascent oxygen.

This being the case, i. e., the modern prevenceptive tablets, filling the vaginal canal with a gas and covering the vaginal walls and the mouth of the womb with an antiseptic foam —why aren't they the ideal, 100 per cent prevenceptive? For a very simple reason: *Because they do not always do it.* And they do not always do it because of one or more things. In order for the tablets to disintegrate and dissolve, they need moisture. Well, some vaginas have a very scanty secretion, are practically dry. In such cases, the tablet may be broken up into pieces, but it remains undissolved, no gas or foam is formed, and it is therefore much less effective as a prevenceptive. In other

cases, in multiparæ, the vagina is very capacious, and one tablet is simply insufficient: two or three tablets are required. It is such and similar factors that account for the failure of various prevenceptive tablets. But where the woman has a normal vagina, with normally abundant secretion and non-lacerated perineum, the effervescent prevenceptive tablets can be used with a high degree of safety.

FORMULAS FOR TABLETS

I give no formulas for the preparation of prevenceptive tablets, because no satisfactory tablet can be prepared extemporaneously by the ordinary retail druggist. They must be purchased from reliable manufacturers who are doing experimental research work and who are making a specialty of their preparations. The best tablets contain chinosol and boric acid as their spermaticidal agents and either sodium bicarbonate and tartaric acid which on coming in contact with moisture form carbon dioxide, or perborates which decompose into metaborates and oxygen or dichlorylsulphamido ben-

zoate. In either case, as explained before, a more or less viscid, gelatinous foam or froth is formed which is in close contact with the os uteri, "protects" it and more or less occludes the opening of the womb.

There is continual improvement in their preparation, and there is no doubt that with further experimentation, the tablets will become still more efficient.

CHAPTER XV

JELLIES

JELLIES have been the last of the chemical prevenceptives to come into use, but have rapidly gained in popularity because of their high degree of reliability and simplicity of use. If properly used—and I shall explain presently what I mean by proper use—it is difficult to see how a jelly can fail to prevent conception. All the modern prevenceptive jellies now come in collapsible tubes, with a long glass nozzle which screws into the top of the tube. The tube is supplied with a key at its lower end, and by turning the key the jelly is squeezed into the nozzle and from the nozzle into the vagina. The opening of the nozzle, when not in use, is closed by a little cork or a rubber cap, and it is best always to keep the nozzle filled with jelly.

In introducing the nozzle into the vagina, the woman must acquire the trick—and it is an

easy trick to acquire—of pushing the nozzle to the very cervix before squeezing out the jelly; after having squeezed out the jelly—one or two teaspoonfuls, approximately, is the proper quantity—the nozzle is to be turned in various directions so as to smear the jelly all over the vaginal walls. It is true that during intercourse the male organ helps to spread the jelly over the vaginal wall, but it is best to help the process by the preliminary "spreading."

THE ADVANTAGES OF JELLIES

The advantages of jellies are many. They can be used immediately before intercourse. It is not necessary to wait, as is the case with tablets or suppositories which must be introduced several minutes before intercourse so as to give them a chance to dissolve. They do not harden, as is sometimes the case with suppositories or tablets which then fail to dissolve and thus lose their prevenceptive power. Jellies are more easily "spread" over the cervix and the entire vaginal canal, thus affording greater protection. In the case of dry vaginas, very

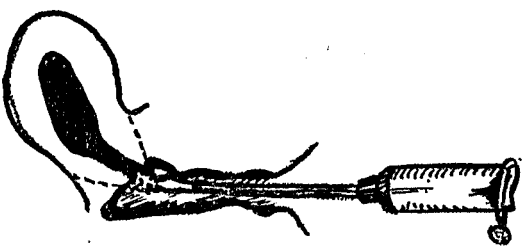
small vaginas, slight vaginismus, etc., the jellies afford a desirable lubricant. The only disadvantage of the jellies, as compared with tablets and suppositories, is that they occupy more space; though the tube and its nozzle are fitted into a small box, the box is more bulky than the tube of tablets or box of suppositories. This disadvantage, however, counts only in case of traveling, or where the sex act has to take place under unfavorable circumstances. In the case of married people who have their home, this disadvantage is of no significance.

Another disadvantage as compared with the modern effervescent tablet: The jelly does not generate any gas which distends the vagina and penetrates into the vaginal folds. Then some finicky men object to the "messiness" of jellies.

FORMULAS FOR PREVENCEPTIVE JELLIES

The solid ingredient of prevenceptive jellies, i. e. the ingredient that gives them the semi-solid consistency, is amylum (starch), tragacanth or chondrus (Irish moss). The liquid

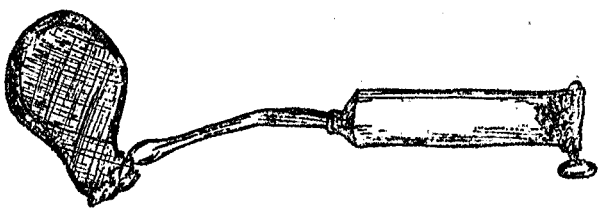
constituent is either glycerin or water or a combination of the two. The antiseptic ingredients are numberless, but lactic acid, boric acid, chinosol and quinine have been agreed upon as the most satisfactory, i. e. possessing spermaticidal power without injury to the tissues and with the least irritation to the male and



MANNER OF INTRODUCING PREVENCEPTIVE JELLY.

female genital organs. From various combinations of the above, numerous jellies are being put on the market. To the question why so many different preparations, why not settle on one as the best, the answer is because men and women are different, and a preparation used with perfect satisfaction by one couple, is strenuously objected to by another, either by the wife or the husband, or both. And for this

reason, we must have different combinations. For instance, glycerin itself, as I have been teaching, is an excellent spermaticide, which means an excellent prevenceptive. And glycerin alone or mixed with some glycerite of boro-glycerin is used by some couples with perfect results. But some men cannot stand glycerin;



METHOD OF INTRODUCING PREVENCEPTIVE JELLY.

their organ gets irritated, develops pimples, etc. While some women cannot stand it, because it makes them "leak" too much. As is well known, glycerin has a dehydrating, depleting effect, and some women, after the introduction of a glycerin preparation, will continue to have a watery discharge lasting for several hours. While this dehydrating, depleting effect is of advantage in inflammation of the uterus,

Fallopian tubes and ovaries, it may have an injurious, weakening effect on normal women. Therefore, where preparations with a glycerin base are objected to, we must prescribe preventceptives which have chondrus jelly as a base.

Glyceritum amyli or glycerite of starch consists of:

Starch	10 grams
Water	20 c.c.
Glycerin	70 c.c.

It is in itself a good spermaticide, but to make more sure we always add some other spermaticidal chemicals. Quinine is excellent, but in jellies we should always use the quinine bisulphate or hydrochloride because the sulphate is much less soluble than the other two salts. While it requires 725 parts of water and 30 parts of glycerin to dissolve 1 part of quinine, the bisulphate is soluble in 9 parts of water and 15 of glycerin, and the hydrochloride in 18 of water and 7 of glycerin. It stands to reason therefore that the bisulphate or hydrochloride will be more effective than the sulphate. But some druggists will use the sulphate even when

we prescribe the other salts because the sulphate is considerably cheaper.

As stated, there are a great number of combinations on the market, but it would be a waste of space to give them all, as they are but slight variations of one another. The following formulas I consider the best.

Glyceriti Amyli	100.0
Ac. Borici	5.0
Ac. Lactici	1.0
Quininæ hydrochlor.	1.0

This, like all other jellies, should preferably be dispensed in collapsible metal tubes (like the tooth pastes and shaving creams) with a long nozzle, preferably of glass, attached.

Where glycerin is objectionable, chondrus jelly or so-called mucilage or Irish moss may be substituted, and the formula would then have the following composition:

Mucil. Chondri	100.0
Ac. Borici	5.0
Ac. Lactici	1.0
Quininæ Bisulphatis	1.0

Glyceriti Amyli	100.0
Chinosol	0.12
Ac. Borici	5.0
Ac. Lactici	1.0

This makes an excellent combination and contains no quinine, against which some people have an idiosyncrasy.

An additional good feature of prevenceptives is the fact that most of our prevenceptives act at the same time as venereal prophylactics. In most cases, in married life, this feature is of little importance. But where there is a possibility of venereal infection, either the condom or the following antiseptic jelly—or still better the two combined—should be used:

Formula for Prevenceptive and Venereal Prophylactic Jelly:

Mercury Oxycyanide	0.2 (3 grs.)
Tragacanth	2.0 (30 grs.)
Glycerin	20.0 (5 drams)
Aqua	120.0 (4 ozs.)

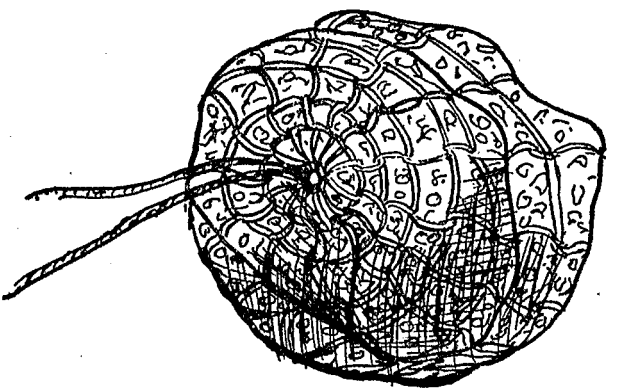
CHAPTER XVI

SPONGES AND COTTON TAMPONS

Sponges and cotton tampons are rather disdained as prevenceptive measures, and yet I know women who swear by them, would use nothing else, and for the masses at large they are highly recommendable, because cheap, easy of application and, let us say it, as efficient as the more costly and elaborate methods. Some women use just a sponge or a ball of cotton; they compress it, pushing it against the cervix, which they learn to feel quite easily and this serves *them* as a dependable prevenceptive. But in other cases, a plain sponge or ball of cotton fails. It is therefore always advisable to saturate or smear the sponge or cotton with some antiseptic solution or ointment before insertion, as explained below.

If a sponge is used, the finest quality, a so-called silk sponge, should be selected, and it

should be dipped in a saturated solution of boric acid(4 per cent), or in very diluted vinegar, or in a chinosol solution (1 to 1000 is sufficient), or in water containing about a teaspoonful of sodium hypochlorite (Zonite, etc.)



"Silk" Sponge, with Net.

to a glass of water. The cotton ball should be quite large, and should be dipped in one of the two solutions just described or smeared over with a boric acid ointment (an ounce of boric acid mixed with half a pound of white petrolatum or vaseline; petrolatum is much cheaper than vaseline, but the latter is more purified),

or with one of the jellies the formulas for which are given in the chapter on jellies. As is known, some husbands object to the use of any prevenceptives; the sponge or cotton tampon, unlike douches, can be used without the husband's knowledge, and many women so use them. They insert them privately and the man is unaware of their presence.

If the sponge or cotton ball is sufficiently large, is saturated in an antiseptic solution or jelly and is placed *against* the cervix, it may be considered an infallible prevenceptive, and needn't be removed immediately after intercourse. It may be left in until morning. Where the woman has short fingers, or is obese (or both) and has difficulty in removing the sponge (or tampon) it should have a little tape run through it, so that the end may protrude a little outside the vagina. It is then easily pulled out.

CHAPTER XVII

A CRUDE BUT SIMPLE AND 100 PER CENT EFFECTIVE METHOD

I FOUND myself once in a small Western village. There was no vestige of a hotel or inn, and I had to request the hospitality of a night's lodging from one of the villagers. The wife pleasantly assented, the husband grudgingly so. The woman was, I thought, about thirty-five. I found out the following morning that she was but twenty-nine, and had been married eight years. And in these eight years, she gave birth to five children (not counting one "miss"), four of whom were hanging around her, while one was sleeping over there "in the cemetery, yonder." And still another was in her belly. When, in the morning, the husband went away to work and I was having my breakfast, the wife, learning that I was a doctor, appealed to me—couldn't I give her

something so she shouldn't have a child every year? She was so young, and at this rate . . . and it is so hard to make a living. . . . What could I give or advise her in such a forsaken hole, about sixty miles from any drug store or railroad station? And yet, I considered it my duty to help her. I noticed that she was using some Javelle water for washing. I told her to put a teaspoonful in half a glass of water; take a stick a little thicker than a lead pencil, make a few notches on one end, and wrap a piece of absorbent cotton tightly around it, dip it in the solution and insert it in the vagina, swabbing it thoroughly before each intercourse and removing it; after intercourse, dip it again in the solution and swab the vagina again thoroughly. Two cotton swabs may be kept ready. The same sticks may be used all the time, but of course fresh cotton must be employed before each sex act. No douche is necessary. It is six years since I gave the poor woman that advice, and not once has she become pregnant. I might add that hundreds of women use this method by my advice, and without a failure. The only

difference being that instead of the stick of wood, women in the city use ordinary forceps or applicators which make it easier to apply and to remove the cotton. Instead of Javelle water, which is irritating to some sensitive vaginas, some women use chinosol (1:500), lysol, zonite, etc. Some use pure glycerin. But the principle is the same: *swabbing* the vagina *and the cervix* with an antiseptic, so that every fold and the *os uteri* are antisepticized and the motility of the spermatozoa is at once destroyed.

This method does not in any way interfere with the sex act, or its pleasurableness; even the feel of the ejaculated semen upon which so many women insist, and which is so necessary for them in order to attain the orgasm is not in any way diminished.

CHAPTER XVIII

THE IODINE METHOD

A SIMPLE and reliable method for the efficacy of which I can vouch is the iodine method, much used by Russian physicians. The method consists in the following: On the day of the cessation of the menstruation, or the day following, the woman visits the physician who injects into the uterus a few drops of solution or tincture of iodine, or swabs out the cavity with a cotton swab dipped into the iodine preparation. No dilatation is necessary, as immediately after menstruation the os is open, and the little manipulation can be performed without any difficulty. This swabbing or injection of iodine generally protects the woman from conceiving during the month. After the next menstruation she comes again, and so on every month. Should, however, the menses fail to appear, i.e. should she think that she has become pregnant,

then she waits a few days—not more than five —and visits the physician, who again swabs the uterus with iodine. This invariably brings on the menses.

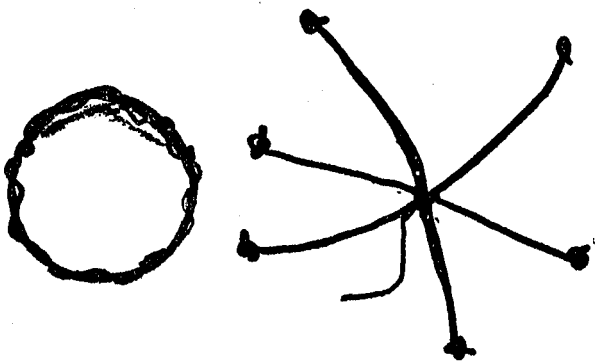
This is a simple method but it can never become one of universal applicability, because it necessitates the woman's visiting her physician regularly once a month, and, if she is "caught," twice a month. And, besides, the second swabbing is really, so to speak, bringing on an abortion, though a very early one, and to this, many of our American physicians would object.

CHAPTER XIX

SILKWORM CATGUT AS AN "IDEAL" PREVENCEPTIVE

CONSIDERABLE publicity has been given to silk as the "ideal" prevenceptive. It was thought, from reports, that some real advance had been made in the field of prevenception. The paper read by the chief protagonist and panegyrist of this method, Dr. Graefenberg, at the Physicians' Birth Control Course, held in Berlin (December 28-30, 1928), has dispelled all illusions on that score. In fact the whole thing may be regarded as a sorry joke. The *referent* entitles his paper "Silk as an Anticonceptive." Further on he tells us that to facilitate introduction he winds silver wire around the silk gut; and finally he comes out with the statement that he *gave up* the use of silkworm gut and *now uses only* small rings of twisted silver wire. That I am not exaggerating, I will reproduce the author's own words in the original: "Neuerdings habe ich auf Silk verzichtet und

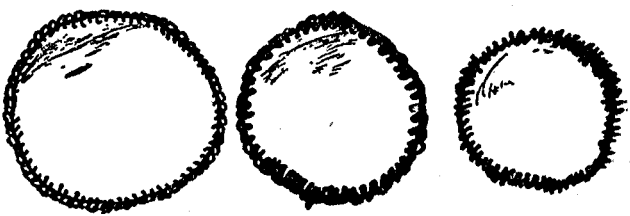
benutze *nur* kleine Ringe aus gedrehtem Silberdraht." And yet he speaks all the time of silkworm gut as the prevenceptive. The author admits that the silk twine which has to be introduced high up into the uterus causes pains,



SILKWORM CATGUT, WITH SILVER RING.

and occasional bloody discharge, rise in temperature and may lead to infection. He admits that the "silk" ring (which has in the meantime become a silver ring) must be introduced and removed by a skilled gynecologist (not even an ordinary physician but a gynecologist!). He admits that the presence of the silk-silver ring induces pathologic changes in the

endometrium, bloody discharge, premenstrual hemorrhage, menorrhagia, etc., and that the cases in which the silk ring may be used must be chosen with care—and yet the method is recommended as an advance! It was an insult to the medical audience, that report of Dr. Graefenberg. Why, *any* foreign body intro-



SILVER RINGS INTRODUCED INTO THE UTERINE CAVITY.

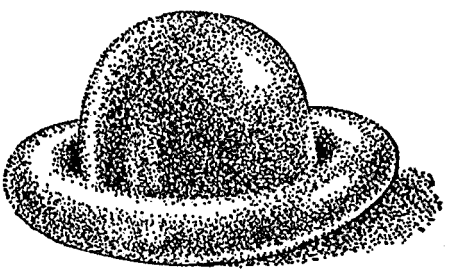
duced high up into the uterus will produce the same effects—if it will not prevent conception, it will surely keep on producing abortions, and cause inflammations and infections in the woman's adnexa.

No, the silk-silver ring must be definitely discarded as a prevenceptive measure. It should never have been thought of as a prevenceptive. We have had enough experience with intra-uterine paraphernalia.

CHAPTER XX

THE CAP OR CERVICAL PESSARY

THERE are several varieties of this pessary, differing in the firmness of the rim, in the height of the dome, the presence or absence of a tab or string for its removal, but the prin-

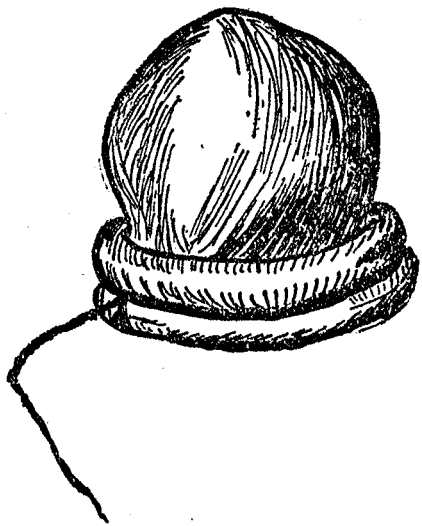


CERVICAL RUBBER CAP.

ciple is the same: to put a rubber cap on the neck or cervix of the womb, so as to occlude the os or the opening into the womb. There is no question that where a cervical pessary fits snugly and well, particularly when it contains within its cavity an antiseptic jelly, the protec-

tion is absolute. But—and unfortunately there are several buts.

1. In some women the cervix is so flat that



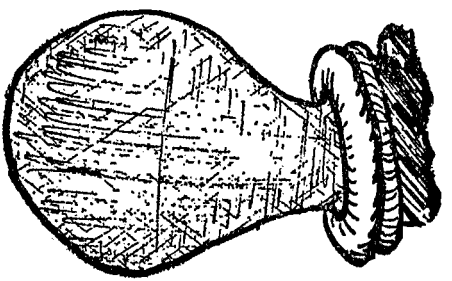
CERVICAL CAP, WITH DOME.

there is no possibility of fitting on any cap. There is no cervix to put any cap on.

2. Some cervices are so flabby and lacerated that if you succeed in fitting a cap on, it would stay on only a very short while and then slip off.

3. The same is true of long, conical cervices. You put on a cap; you think it fits fine, the next day you look and you find it lying free in the posterior cul-de-sac of the vagina.

4. It is absolutely impossible for many women, particularly stout women with short, stumpy fingers, either to place the pessary

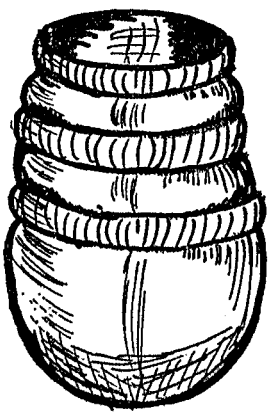


CERVICAL CAP, PUT ON.

properly or to remove it—particularly the former. And of course it would be absurd to expect them to go, each time they expect to have sexual intercourse, to a physician to put on the pessary, and go again next morning to have him remove it.

5. Some women who do not wish to be bothered with the putting on and the removing of

the pessary before and after each intercourse leave it on the whole month, removing it only before the oncoming menses. This is fairly permissible with women who have practically no cervical discharge. But where there is consider-



Set of Metal Cervical Caps.

able or even a moderate amount of discharge, bad results, such as erosion of the cervix, may follow.

But leaving out those cases to which the cervical or cap pessary is not suited, it remains to be said that in *suitable* cases this type of pessary offers excellent protection. We know

women who are most expert in putting on and in removing the pessary; they can do it in a moment's time, and they want no other method. But that even such women do not rely on the cap alone absolutely is seen from the fact that before putting on the cap they put inside it about half a teaspoonful of an antiseptic spermaticidal jelly.

THE SILVER CERVICAL PESSARY

A pessary greatly in favor in Austria is the silver cap pessary. It is a small cap made of a silver alloy or of gold, of different sizes which fit tightly or snugly around the cervix. The protection seems to be absolute. The cap is left on the whole month, being removed only, by the woman herself, before menstruation. After the menses, she goes to her doctor, who fits it on again. The cap, like all cap pessaries, is suited only to normal, fairly fleshy, not too hard or conical cervices. A douche is recommended after sexual intercourse, but some women consider this unnecessary. They say that they have used the cap for years without

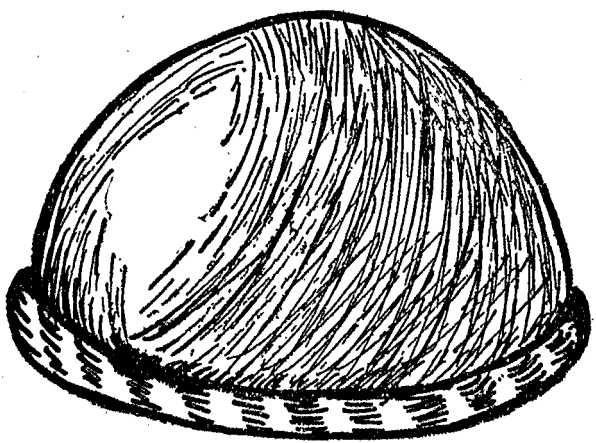
taking douches and nothing ever happened. It is likely that besides the mechanical occlusion which the cap affords, there is a chemical reaction around the os—probably increased acidity, which counteracts impregnation.—So high is the reputation of this metal cap, particularly among women of German extraction, that we have known some of them to travel all the way to Vienna to have one fitted on. They believed that there they knew better how to do it, and that a cap fitted in Vienna would be more effective.

CHAPTER XXI

THE MENSINGA, RAMSES OR DIAPHRAGM PESSARY

This pessary, invented about ninety years ago (in 1842) by Dr. Mensinga of Flensburg, Germany, and known as Mensinga's occlusive pessary (pessarium occlusivum, Mensinga), has been used very extensively on the European continent and in England, and has lately come into extensive use in this country also.—If you cut a hollow rubber ball in two halves, you will get the principle of the Mensinga pessary. Into the rim is "welded" a flat steel or a coiled spring. This rubber pessary with a rigid but flexible rim is introduced into the vagina with the concavity upward, so that it covers the cervix and the rim rests on the vaginal walls, thus forming a diaphragm or wall, separating the vagina into two halves. The semen being deposited into the lower half of the vagina, is prevented from penetrating into the os by the

barrier of the rubber pessary. If the pessary is a perfect fit, that is, if it completely occludes the lumen of the vagina, without at the same time exerting too much pressure on the vaginal walls, it is a safe prevenceptive. But, alas, this

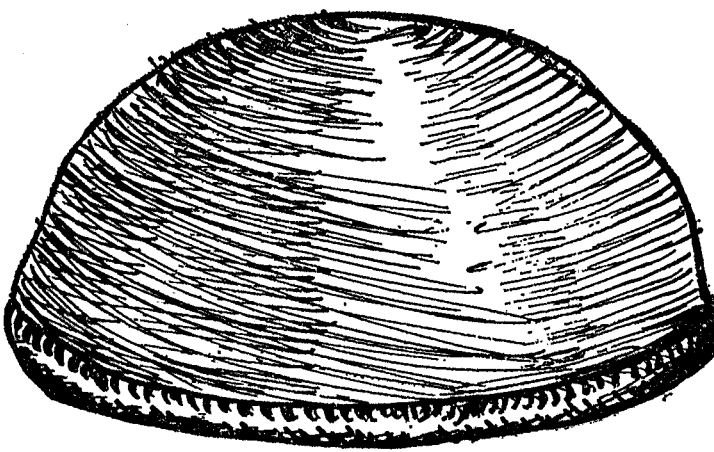


DIAPHRAGM PESSARY.

is not always the case, and then this pessary is not any more "safe" or dependable than many of the other recommended prevenceptives.

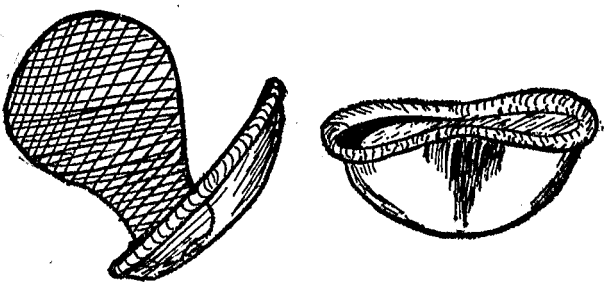
A few more words on this very point will not only be not out of place, but will be very much *à propos*. Numerous encomiums have been be-

Mensinga, Ramses or Diaphragm Pessary



DIAPHRAGM PESSARY.

stowed upon the diaphragm pessary recently, and many panegyrics have been sung in its honor. That the panegyrists themselves are not so certain of its dependability is seen clearly from the fact that in addition to the pessary they recommend the use of a prevenceptive



DIAPHRAGM PESSARY AND METHOD OF ITS APPLICATION.

jelly. Why? If the pessary invariably occludes the cervix, separating it from the lower half of the vagina where the semen is deposited, why the need of an antiseptic jelly? If it does not occlude it absolutely, and there is danger with its use of the spermatozoa penetrating the cervix, then it is a broken reed, and deserves no greater praise and recommendation than several of the other prevenceptive measures that

we possess. And if, as its advocates recommend, the pessary is always to be used in combination with the antiseptic jelly, how can we apportion the protection contributed by each? How can we know that it is not the jelly that "does more," and *is of more importance* than the pessary? To speak frankly, this has always

METHOD OF INTRODUCING PESSARY.

been my opinion: that the jelly properly applied is at least as reliable an agency as the pessary.

And it is my opinion that the diaphragm pessary, like the cervical or cap pessary, will never become the universal prevenceptive or even the prevenceptive of choice, and for the following reasons.

1. Used alone, without the addition of an anti-

septic jelly, it has a considerable number of failures to its credit—or discredit.

2. There are a very great number of women who to save their lives cannot introduce the pessary—or remove it after it has been introduced for them, particularly the former. And this applies not only to short obese women, with stumpy fingers. I have seen a number of normal, slim, intelligent women who could not acquire the knack of introducing the pessary properly. And it is not fair to give the impression that every woman can easily introduce a Mensinga or Ramses occlusive pessary.

3. In cases of a lacerated perineum, relaxed vaginal walls, with perhaps cystocele or rectocele, or both, the pessary is useless. It won't stay. In marked anteversion or retroversion it is also of little use.

4. It is not correct to say that with the occlusive pessary intercourse is *perfectly* normal. It is certainly not so normal as when the jelly alone is used. The sensitive woman as well as the sensitive man feels when something is interposed between the glans and the cervix.

And then some women have their orgasm only when the male ejaculate comes in immediate contact, irrigates, so to say, the cervix and the vaginal fornices. This, the diaphragm pessary prevents.

5. But the real obstacle to the occlusive pessary becoming the universal prevenceptive is the fact that its use necessitates the services of a physician. While this is no real obstacle in large urban communities, particularly in the few large cities which have birth control centers, nor for the well-to-do, intelligent, professional or middle classes, it is an almost insurmountable handicap in small, remote or rural communities, and also as far as the broad masses in general are concerned. We have stated more than once that as far as the well-to-do classes are concerned, they have no birth control problem. For them it is settled. They know how to help themselves. It is the vast poor masses, the working classes that are more in need of birth control, and they need a prevenceptive which is cheap, simple, can be easily applied and which does not need the services of

a physician. There are still now, in our United States, many small communities the inhabitants of which are born and die without the benefit of the medical profession, and for this reason the pessary is not likely to become a popular favorite.

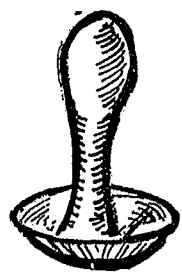
What in our opinion the universally applicable and serviceably popular prevenceptive is likely to be, will be stated in another chapter.

CHAPTER XXII

INTRACERVICAL AND INTRAUTERINE PESSARIES

A GREAT number of pessaries have been devised from time to time which enter the cervical or uterine cavity. Some are in the form of an elongated collar button, some in the shape of a wishbone (whence their name, wishbone pessaries), etc. Some are made of gold, some of silver, some of an alloy of two or three metals, some of aluminum, some of celluloid, some of glass and catgut. I shall not stop to describe them in detail, because I condemn them all. Most of them are not so much prevenceptives as abortifacients. That is, they do not really prevent conception, but when conception has taken place, they bring about a miniature abortion by their presence as a foreign body. For the pessaries made out of various alloys it is claimed that when *in situ* they generate an electric current which renders the cervical se-

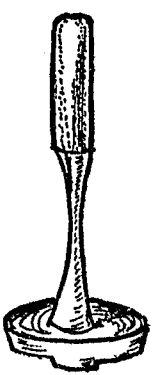
cretion acid, thus preventing the entrance of the spermatozoa. This is to me rather doubtful. I am inclined to think that their modus operandi is the same as that of the other intrauterine pessaries: that of a foreign body which brings about an abortion. I condemn the intracervical and intrauterine pessaries because



COLLAR BUTTON INTRACERVICAL PESSARY.

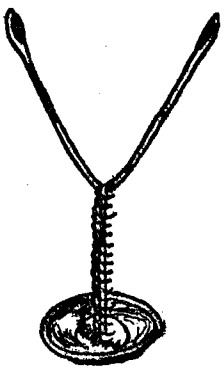
they are apt to produce irritation, inflammation and infection. I have seen some serious results from their use—among other things some of the most obstinate cases of endocervicitis and leucorrhea. But fairness demands that I state that many women wear them for months and even years without any ill effects. I know the case of a woman who wore a wishbone

intrauterine pessary for three years without once removing it, and she did not seem to be any the worse for it. But such cases are exceptional. That they are in many cases superior to any other pessary, I shall not deny either.



INTRAUTERINE STEM PESSARY.

GLASS AND CATGUT CERVICAL PESSARY.



WISHBONE INTRAUTERINE PESSARY.

For while they *must* be fitted and inserted by a physician, they need not be removed and reapplied once a month as is the case with the gold cervical cap, because menstruation can take place with them *in situ* and this is the reason why many women prefer them to any other method: they can wear them for several months

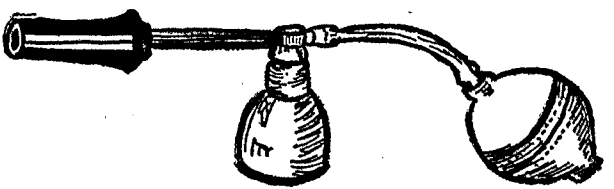
without giving them a thought. But in this very advantage lies their condemnation: because they cause no trouble and because they need not be removed before even menstrual periods, women are very likely to leave them in for months, or even as I mentioned before, for years; they even seem to forget about them until some inflammation reminds them of their presence.

Under exceptional conditions, for temporary use, an intracervical or even intrauterine pessary would be permissible. For instance, a man and wife are to go on an exploratory expedition lasting several months. In such a case one of the above-mentioned pessaries might be the appliance of choice. But for general routine use they are not to be recommended.

POWDERS AND POWDER BLOWERS

I am devoting but little space to powders as prevenceptives, because I do not consider them practical. Not that there are not perfectly efficient prevenceptives in powder form, but their introduction into the vagina is awkward and

the powder blower is a cumbersome piece of apparatus and the holes of the nozzle not infrequently get clogged up. In the treatment of leucorrhea and cervical erosions where the



VAGINAL POWDER BLOWER.

physician applies the treatment personally, powders can often be used to great advantage, but where the person has to apply the powder herself, failure to apply the powder properly may often occur.

CHAPTER XXIII

THE BEST PREVENCEPTIVE OF TO-DAY

If I were asked to state what in my opinion was the best and most universally applicable prevenceptive so far discovered, I would say:

Taking into consideration every prevenceptive device known, comparing their advantages and disadvantages, marking off those which come nearest to answering the seven requirements of an Ideal Prevenceptive, the answer is: A properly made and properly applied prevenceptive jelly. It makes little difference what antiseptic or acid is used in the jelly, quinine, chinosol, boric acid, lactic acid, salicylic acid, etc. In my opinion a jelly containing boric acid, chinosol *and* lactic acid is the best. There are no patent or proprietary rights on the formula. Every fairly competent druggist can prepare it. It is most conveniently used in metal collapsible tubes with a long slightly curved glass

nozzle attached. The poor can have the jelly made up in pound jars, and use a cotton ball or sponge dipped into the jelly and inserted into the vagina before each intercourse.

Next to the jellies come the effervescent tablets; and next to them the suppositories. A pessary plus prevenceptive jelly increases perhaps the safety to a slight degree, but the reasons why the pessary can never become the universal prevenceptive have been sufficiently explained in a previous chapter.

CHAPTER XXIV

IRRITATIONS CAUSED BY PREVENCEPTIVES

Some men come to you complaining that they cannot use this or that prevenceptive because it causes them some irritation: the head of the penis or the prepuce becomes red, irritated, itchy. This is particularly the case with men who have not been circumcised and have long prepuces, with considerable secretion of smegma.

Some prepuces cannot stand the mildest chemical. To illustrate: A man refused to let his wife use certain suppositories because his organ felt irritated after their use. The salicylic acid which was thought to be the offending agent was left out of the formula. The result was the same. The chinosol was then left out, and finally a trial was made with a suppository consisting of nothing but cacao butter. The man complained of irritation just the

same. The irritation was insignificant and would disappear in a day or two with the use of talcum powder, but still the man refused to use any prevenceptive. In such cases the gentleman should be told to abstain from intercourse altogether or to have himself vasectomized, or to keep on impregnating his wife, year after year, if he is so finicky that in order to limit the number of his offspring he is unwilling to undergo the least discomfort.

Women complain much more rarely of the discomfort caused by prevenceptives. First the vagina is much less sensitive to chemicals than is the male glans and prepuce; and second, an undesired pregnancy means so much more to the woman than it does to the man that she is not likely to make a fuss over a little discomfort or irritation.

Long ago I had occasion to treat some cases of vaginal irritation and erosion caused by strong solutions of bichloride or phenol. I have not seen or heard of any cases of vaginal or cervical trouble caused by the modern prevenceptives. To claim that a *vaginitis* can be in-

duced by chinosol, boric or lactic acid is in my opinion most strange. In the thousands of cases to whom we recommended the use of various tablets, suppositories or jellies, we have not come across a single case of vaginitis. On the contrary, I have seen great improvement follow their use in cases of leucorrhea and endocervicitis.

Idiosyncrasy against Quinine. It is well to bear in mind that now and then, rather rarely, we come across a person who has an idiosyncrasy towards quinine. So sensitive are they to this alkaloid (and its congeners) that even a small quantity of a hair-wash containing quinine and applied to the head will cause a scarlatinal rash, severe tinnitus aurium and the various other symptoms of quinine poisoning. Of course, with such people we must avoid suppositories or jellies containing quinine in any form.

Some Insignificant Objections to Prevenceptives. Some men and some women, but particularly men, have some other objections to offer to the various prevenceptives. As far as with-

drawal and condoms are concerned, the objections are legitimate and well justified. But some men object to the use of suppositories because they don't like the smell of the cacao butter or the greasy feeling; some object to jellies because they don't like the "mess." Some women don't like the bother of introducing the pessary, or of going down from the bed to use the douche—and so forth. To such people we say: Well, if you object to the use of this, that and the other, then abstain for a few years until we shall have invented a perfectly reliable and perfectly unobjectionable prevenceptive—or go on having a baby every year until the wife is past the child-bearing period. —Really, avoiding a yearly addition to the family, escaping the discomforts of nine months of pregnancy, the agony of labor, the worry and pain of bringing up undesired children, etc., etc., is worth a little trouble, inconvenience and even discomfort.

CHAPTER XXV

FALLACIOUS POPULAR METHODS

The number of measures, methods and remedies in the efficacy of which as prevenceptives some people believe with an unwavering faith is truly legion. Many of them are quite worthless, some of them possess slight or occasional value, but fail more often than not and not infrequently lead to disappointments and tragedies. It would seem a waste of time to discuss the ineffective methods, but for the fact that many men and women believe in them and rely on them until they discover their error, when, alas, it is too late. Destructive criticism, it should be superfluous to add, is sometimes as useful as is criticism of the so-called constructive variety.

It is impossible of course to enumerate all the bizarre beliefs and ideas prevalent among certain classes of the population; so we will

limit ourselves to those that are most widespread and are still more or less in vogue.

HOLDING BACK

Many are the false notions and myths entertained regarding our sex life. The belief that by holding back, by not letting herself go, by not participating but remaining quite passive during the act, the woman can avoid impregnation is one of the most widespread, the most implicitly maintained. It is very commonly believed that a woman cannot conceive unless during the sex act she can experience a thrill, unless she has an orgasm. Some even believe that in order for conception to take place, both partners must reach the culminating point at the same moment. I will not say that there is not a grain of truth in this belief, that there is not some foundation for it. The mucous plug which occludes the os uteri is in some women very viscid, and it is only in moments of great sexual excitement, of ecstatic frenzy reached during the orgasm that the plug is expelled and the way is made clear for the spermatozoa

to penetrate the interior of the uterus. If the woman remains quite passive, the plug remains *in situ* and conception becomes difficult or impossible. But to *rely* on "holding back," or passivity, as a reliable prevenceptive is to be exposed to numerous disappointments. As I stated many times before, "women as cold as icebergs or frigidaires, as apathetic as wooden idols, wives who during their entire sex life never experienced an orgasm, can and do conceive with exasperating and despair-causing facility." We know that a woman may even conceive when totally unaware that intercourse has taken place, as when in a deep sleep, unconscious from swooning or an anesthetic, etc. In artificial impregnation, when the semen is injected into the uterus with a syringe, the woman surely experiences no thrill or orgasm, and yet pregnancy may take place.—So, I repeat, to rely on passivity on the woman's part during the sex act as a prevenceptive, is to lean on a very frail support indeed.

That this holding back on the part of the woman is apt to injure her, weaken her nerv-

ous system and lead eventually to frigidity, to a disgust with the sex act, is well known to every experienced sexologist, and I have already discussed it in several places. And it is not necessary to dilate upon it here.

THE SAFE PERIOD

Fallacies and falsehoods have a long life, and in spite of the demonstrable numberless failures some people still continue to believe in the existence of a "safe" period, i. e. a period during each month when no woman can become pregnant. There is no such period, old women, amateur sexologists and theological physiologists to the contrary notwithstanding. There is not a day in the month in which the human female may not become pregnant. From various individual experiments, from results obtained during the world war in Germany, when soldiers sent home on leave to their wives were asked to note the time of the menstrual month when they had sex relations with their wives and the resulting or nonresulting pregnancy, the truth seems to be this: the highest chances

for conception are during the week immediately following menstruation, during that week woman is most fertile; the chances for conception gradually diminish until the week preceding menstruation, when the fertility is at its lowest ebb. Some authorities like to say that during that week woman is practically sterile. This is putting the matter too strong, though it is true that *some* women seem to be unable to conceive during the premenstrual week.

But for the generality of women to *depend* on a safe period means running the risk of cruel disappointment and tragic deception.

LACTATION

Lactation or nursing a baby is often made use of as a prevenceptive, and this, perhaps as strikingly as anything else, demonstrates the difference in different people. Some women just can't get pregnant when they nurse; if they nursed the child up to two years they would not conceive; and in the East, we find women nursing their children up to three and even four years; and as long as they nurse, they do

not become pregnant. Other women do not conceive up to the fifth or sixth month after childbirth. And there are still other women who may nurse most industriously and yet they become pregnant a month or two after childbirth! And, again, some women may not have conceived during several lactations, and then suddenly undergo a change in this respect. I know one rather tragic case of this character. A woman had had three children whom she nursed until they were over a year old, and she did not become pregnant during lactation. While she was nursing her fourth child, her husband went to Europe and to the Orient for a trip which took him some five months. Relying upon her former immunity, she indulged in illicit relations with a childhood friend and promptly became pregnant. She did not suspect anything until the enlarged uterus showed unmistakably what happened. When the husband returned, he had no difficulty in arriving at the conclusion that the child born several months after his arrival could not be from him.

While lactation is a perfectly safe prevenceptive measure with some women, it is a broken reed with others. And it is well to bear in mind that conception can occur during lactation even if the woman does not have her menses. That women who menstruate during lactation are apt to become pregnant, goes without saying.

MICTURITION AFTER INTERCOURSE

Some women believe that if they urinate immediately after intercourse they cannot become pregnant. Utterly ignorant of anatomy they think that the urinary and the vaginal canal are one and that the urine in passing washes away the semen. They are quite surprised when told or shown that the two canals are quite separate. That in squatting to urinate some of the semen may be squeezed out, particularly in parous women with a torn perineum, is true; but to depend upon it as a means of prevenception, is to lean on a very broken reed indeed. The same is true of deliberately sneezing and coughing. Some semen is squeezed out by these

methods, but it does not require many spermatozoa to cause conception. One suffices.

REVERSED POSITIONS

Some women and their husbands believe that by reversing the usual position during intercourse, that is, with the woman "superior," they can avoid impregnation. The explanation of the alleged efficacy of this method is that in that position the semen runs out, and also that the male organ cannot reach the cervix. There is *some* truth in both of the above explanations. But with some women this is the surest way of becoming pregnant. In cases of extreme version where pregnancy does not occur, and the women are anxious for a child, we advise "reversed positions" or *coitus more ferarum* and pregnancy often results.

INTERNAL REMEDIES AS PREVENCEPTIVES

That the people have a pathetic faith in the power of drugs, taken internally, to produce an abortion is well known. If it were not so the venders of worthless emmenagogue pills, like

Chichester's, for instance, would not become millionaires. But it is not so well known that among certain classes of people, and not only of the poorest strata, the belief prevails that certain drugs taken by mouth will prevent conception. We often receive inquiries to this effect. Is it true that if a man takes a dose of such and such drug the woman will not become pregnant? Spirits of turpentine seems to be the drug in which most faith is had. And one correspondent even tried to convince me that the drug possesses real virtues as a prevenceptive. If he takes half a teaspoon of spirits of turp (as he called it) before the sex act, his wife never gets in the family way. Only once it failed.

Of course, there is nothing to it, and there is no drug in either the mineral, vegetable or animal kingdom, which taken internally by mouth possesses prevenceptive properties. It is possible that we shall succeed in elaborating a biologic product (a preparation of spermatozoa) which will be a really efficient temporary sterilizer, whether administered orally or hypoder-

mically, but that time is not yet here, though considerable work is being done along that line. (See paragraph on spermatoxins in chapter XXVII.)

CHAPTER XXVI

MISCELLANEOUS TOPICS

I AM as well aware as any reader may well be that the subject of continence does not belong within the pages of a sane, rational and *practical* book on Prevenceptives. And yet, as that remedy is so often recommended by well-meaning theologians and quasi-scientific physicians as the ideal method, and we are told that self-control is superior to birth-control, I cannot refrain from saying a few words on the subject.

CONTINENCE

Yes, as a prevenceptive continence is ideal. With the exception of an occasional case of immaculate conception, it *is* 100 per cent sure. It is cheap, and it requires no paraphernalia of any sort. But evidently it is not a feasible method, for otherwise it would have, by this

time, gained a somewhat more general acceptance.

I shall not devote much space here to continence and its influence on the physical and mental health of men and women, for I published a whole volume on the subject. I will merely say here that my views on continence will give comfort neither to the ascetics and hypocrites on the one hand, who claim that continence for an indefinite period is quite an easy matter and is not fraught with any injury, nor to the sensational sex fakirs on the other hand, who claim that sex is the whole of life and that continence for a year or two, or even for several months, is sure to be followed by the direst disasters, physical and mental. I believe that earnest, non-idle men and women engaged in engrossing occupations can very well go for several months or even a year or two without sexual relations without any injury worth speaking of. Some temporary discomfort—that's all. But, of course, to recommend continence as a permanent condition, *particularly to married people,* is too absurd to deserve any discussion.

SEX RELATIONS FOR PROPAGATION ONLY

There are some men and women—estimable people they are, we are assured—who believe, or want to make us believe, that there is no birth control problem, for they claim that sexual intercourse is for the propagation of the race *only*, that sex relations should be had only when children are wanted; at any other time the act is vulgar, sinful, brutish and lustful. This claim, whether sincerely believed in or hypocritically mouthed, is too idiotic to deserve serious discussion. As three, four, or let us say a dozen (!) children is considered nowadays sufficient for any family, many couples should have to indulge only a dozen or two dozen times during their entire life! (Intercourse during pregnancy according to those purity apostles would be reprehensible and criminal because wasteful and not serving any longer the purpose of procreation.) Yes, as many women conceive from one sex act, those who want only two, three or six children would be limited to two, three or six acts during their

entire married life. But for the desire for children, they might as well have themselves castrated. Simpler and easier of execution than life-long continence. No, neither "self-control," nor sex relations for propagation only can be recommended as an acceptable prevenceptive, and neither is a solution of our birth-control problem.

MASTURBATION AS A PREVENCEPTIVE MEASURE

It is not uncommon for some physicians to recommend masturbation to unmarried men as a safe, free from the danger of infection, substitute for illicit relations. One well-known American sexologist was highly in favor of it and recommended it in his books. But it was only recently that we learned of a physician who recommended it as a prevenceptive! The wife has kidney trouble, having gone through several dangerous eclamptic seizures in her last labor, and the doctor said that she must not ever become pregnant again. When the husband asked him for a remedy to prevent her from conceiving, the good doctor told him that

the best remedy was abstinence. When the man said that he could abstain for months, but not for years or forever, the doctor told him that the next best thing was to relieve himself by masturbation. "It won't hurt you, and it is surer than withdrawal or any contraceptives, in which I do not believe." The patient did not take the doctor's advice, obtained the proper information elsewhere, and he and his wife are living a normal sex life under the protection of a prevenceptive jelly.

CHAPTER XXVII

STERILIZATION BY X-RAYS AND RADIUM

That the X-rays will cause sterility is a well-known fact. Before the action of Roentgen's great discovery was fully known many men and women who worked with the rays without proper protection, found themselves involuntarily sterile. We can now measure accurately the dosage of the Roentgen rays, and we know that small doses stimulate the activity of the ovaries; larger doses will cause temporary sterilization lasting several weeks to several months; while with still larger doses we can cause necrosis of the ova-generating portion of the ovaries with resulting permanent sterility. Of course this will never become a popular method; Roentgen irradiation can only be administered by an expert (otherwise great damage can be done), and few women can afford or will agree to go to a physician every month or

two. It is being done, however. Some physicians add a fairly large amount to their incomes by having women coming to them regularly once a month. They administer a mild dose of the x-rays; for treatment they charge ten dollars, and the woman is considered "safe" for that month.

No, the x-rays (and the same is true of radium) will never become a popular or even desirable method. We do not know yet all the remote effects of the rays; some women are so susceptible to the effects of the rays, so sensitive, that though we intend to produce but a temporary sterilization, the result may be permanent. The sudden bringing about of an artificial menopause may have a profound effect on the woman. Not only the oögenetic, but the hormone-producing parts of the ovaries may be destroyed. In short, it is too sharp and too uncertain a weapon.

But whatever may be the opinion of different authorities as to the value of the x-rays as a prevenceptive, one thing is *sure:* If a woman got pregnant soon after an x-ray or radium

irradiation, and particularly if it is found that she was pregnant while being irradiated, an abortion should invariably be produced. If allowed to go the term the child is quite likely to be physically or mentally defective, or both, or it may be born a monstrosity. It isn't *necessarily* the case, but what parents will want to, or have a right to, take the chance?

SPERMATOXINS

Experiments are being conducted with preparations of spermatozoa which when injected into the female cause temporary sterility. But the whole work is still in the experimental animal stage, and is of no practical value as far as the human female is concerned. We are keeping in close touch with the work and as soon as worth-while results are obtained—worth while in *practice* and not in theory or on paper—we will announce them to our readers in a supplement or in a new edition.

The same may be said of the experiments with vitamin E whose presence seems to be necessary for fertility.

CHAPTER XXVIII

LIGATION OF THE FALLOPIAN TUBES AND SALPINGECTOMY

LIGATION or resection—the two procedures are generally performed together—of the Fallopian tubes in the female, corresponds to ligation and resection of the vasa deferentia in the male. When a woman because of a narrow or deformed pelvis, tumor, etc., is undergoing a Cesarean section, be it the first or the nth time, and *asks* to have her Fallopian tubes resected and obliterated, the physician is not only justified in doing it; it is his duty to do so. To refuse is moronic brutality. But to subject a normal, healthy woman to the dangers of this operation, which is a major operation even when performed by the vaginal route, when the corresponding operation of vasectomy in the husband is so much simpler, so much freer from danger, is reprehensible indeed. It is

cruel, and yet I knew a husband who would not have himself vasectomized but insisted that his wife should undergo the operation of salpingectomy. He was no doubt looking towards the future when he might perhaps want to remarry and become the father of children. He was attributing his refusal to undergo the operation to the fear that the vasectomy might affect his sexual power. But his explanation did not ring true. On the other hand, there are many husbands who accept vasectomy without hesitation when the wife's condition makes her avoidance of pregnancy an imperative, vital necessity.

Gosney and Popenoe's report on the effects of salpingectomy on women (see chapter on Vasectomy) is as follows:

TESTIMONY OF NORMAL WOMEN

Histories of 420 normal women who had been sterilized in private practice were also gathered, and details were gotten as to the sexual life of 165 of these, either through (in the majority of cases)

inquiries by field workers, or through the woman's statements to her own physician.

These patients represented a wider range than our male histories, both in education and in health. The mean age is thirty-four years, the range less than that of men, since a woman is seldom sterilized after she passes the child-bearing age. Hence only two or three of these were over fifty at the time of operation.

Of the 165, we found that ten had had no opportunity to test the result, either because they had not fully recovered from the illness when interviewed or because they had not lived with their husbands since. Excluding these, there are 155 who were able to give first-hand testimony as to the effect of salpingectomy on the sexual life. Seven of them noted a decrease, but several of these had been operated upon recently, after a long siege of ill health, and may yet come back to normal; the others showed various special condi-

tions which explained the decrease but had nothing to do with the operation.

There were ninety-two who reported no change whatever in their sexual life, while fifty-six—more than one-third of the total—stated that their sexual life had been improved by the operation. In most cases this improvement was ascribed either to an improvement in physical health, or, more frequently, to removal of the possibility of pregnancy, which had caused fear of, or antagonism towards, sexual intercourse.

The testimony of the women is, then, just as weighty as that of the men. A diminution of sexual activity or enjoyment is almost never reported after sterilization, and when it is reported, the cause for it is usually obvious and has nothing to do with the sterilization. And an actual improvement in the sexual life is reported by one man in seven, one woman in three.

The increases, like the decreases, are probably to be explained on other grounds

than the mere effects of the operation on the individual. So far as can be judged, the operation has no effect—except to prevent parenthood.

CHAPTER XXIX

ENVOI

NEITHER the x-rays, nor radium, nor spermatoxins, nor vitamin E-free diet, nor any operative procedure on the female, be it salpingectomy, cauterization of the endometrium or obliteration of the uterine cornua by the electric cautery, will ever gain universal or general acceptance as a prevenceptive measure. Some of them are uncertain, some are too certain, i. e. permanent and irrevocable, while some are not free from danger and undesirable after effects.

Not from those directions will our ideal prevenceptive come. Not even from the pessary manufacturer. It is possible that man's inventive genius, which can measure and weigh the stars, which has enabled us to circle the globe in a few days, which has given us the marvel-

ous radio and television, will invent some sort of pessary which will encircle and occlude the cervix perfectly—every variety of cervix—which will open outward and downward so as to permit the catamenia and the endometrial secretion to escape, but will offer an impassable barrier to the most abundant and virile spermatozoa, a pessary which the women will be able to wear indefinitely without any injury, being removed only when a child *is* wanted—perhaps such a pessary will be invented. But my real hope lies in chemistry. I am looking forward to a tablet or suppository or jelly which when introduced into the vagina will instantly so antisepticize it, whether by the aid of a gas or some other means remains to be seen, and keep it in an antiseptic prevenceptive condition for several hours—and without the slightest injury to the tissues—as to make conception *impossible.*

That time is not yet, but it is rapidly coming. And when it does come, birth control will become really universal, and its greatest benefits, i. e. its use by the lower strata of society and

the backward, culturally and economically low races, will then be realized.

And when Birth Control by Prevenception becomes truly universal, when both families and entire races will be enabled to maintain an *optimum* birth rate, then many of the world's most painful and most complex problems will have been solved, or will be near solution.

POSTWORD

Physicians who have studied this book have been kind enough to say that they have derived great benefit from it; they praise its simplicity, clarity, its freedom from padding and particularly the fact that the author has no axes to grind, no preparations of his own—jellies, caps, pessaries etc.—to sell or recommend, and can therefore be absolutely free from any bias, conscious or unconscious.

About the simplicity and clarity the reader is a better judge than the author; but about freedom from bias, from any entanglement, from any commercial interests, this I am glad to corroborate in the most emphatic manner. Every prevenceptive, chemical preparation or mechanical appliance, is examined on its merits, and judged according to our findings. The other day, for instance, a preparation was presented to us with great claims, as a great improvement

on all previous prevenceptives. Careful examination and trial showed that it was nothing but a complicated condom, which a woman could use instead of a man, and having all the disadvantages of the former plus some of its own. To introduce it in the vagina, the woman has to put herself in the lithotomy position and introduce the condom by the aid of a test-tube. No, this is very far from being an ideal prevenceptive.

I have abstained from introducing statistics into this practical book because I consider them misleading and frequently worse than useless. No prevenceptive is fool-proof. Unintelligently used or carelessly used the best prevenceptive will fail; in order to compare the value of various prevenceptives, we would have to compare the various users, their intelligence and the care with which they have used the preparations. And as this is not feasible, the results are often misleading. As to the statistics given by people who have some preparations or appliances of their own to sell, the figures are unfortunately often "manipulated"—exaggerated or falsified.

Hence I preferred to present my judgment concerning each method without any statistics.

The ideal book on Prevenception has not yet been written because we do not yet possess the ideal prevenceptive. But should we cease writing books on Therapeutics because we do not possess ideal one hundred percent effective therapeutic agents for every disease?

Even though not yet perfect, books dealing with practical methods of prevenception are among the most *useful,* the most *important* in a physician's library. A physician without any prevenceptive knowledge cannot do his whole duty by his patients.

I have given in this book several formulas for suppositories, jellies, etc. Those who have the skill and patience can make those preparations themselves. But there are on the market a number of reliable preparations which can be easily obtained in most up-to-date drugstores or directly from the manufacturers.

I am often asked to recommend a certain preparation, to state which preparation I consider the best and so forth. This I have always

refused and shall always refuse to do. It is not only because an advocate of a cause should, like Caesar's wife, be above all suspicion, should be free from any shadow of a financial interest, but also because there is no best; all jellies of today, for instance, possess practically the same efficiency. And as I explained more than once it is not so much *what* is used as *how* it is used, how intelligently and carefully it is applied, that determines the result, that makes the difference between success and failure.

As to the *general* class of preparations which I consider the best, I stated that in the text. But do not ask me to recommend an individual preparation. I shall not do it.

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THE SAFE PERIOD:
or
THE NATURAL METHOD OF BIRTH CONTROL

Because the use of chemical and mechanical prevenceptives has certain disadvantages, because they are not 100 per cent certain in 100 per cent of all cases, because their use is now and then troublesome, because certain facilities are occasionally lacking, because in remote backwoods places they are not always easily obtainable, because some people object to their use on aesthetic and even moral grounds, because of their cost, which with poor people is an item not to be disregarded, because the Catholic church officially still brands their use as sin—because of the above reasons, attempts have been made to find a substitute for artificial prevenceptives.

From time immemorial, a vague idea prevailed that during certain periods of the month a woman is less apt to conceive than during others. But it is only a decade or so since

attempts have been made to determine the period on a scientific basis.

And in the "safe period," that is, the days in the month during which the woman is supposed to be sterile, i. e., unable to conceive or to become pregnant, many consider that such a substitute has been found.

Cappelmann's theory that the mid-month was the "safe period" has long ago been proved to be not merely inadequate but utterly false, the diametrically opposite being true.

During the past two years, the Ogino-Knaus theory, a theory developed independently by Dr. Kyusaku Ogino of Niigata, Japan, and by Professor H. Knaus of Graz, Austria, has attained a great vogue. And as this method of prevenception is physiologic or "natural," doing away with the use of chemical or mechanical prevenceptives, which are considered "unnatural," it has, therefore, received the blessing of the Catholic church and has spread like wildfire throughout this land of ours. And I have received numerous inquiries as to what *I* think about the reliability and safety of the method.

Well, what is the Ogino-Knaus theory of the safe period for women?

Now, first of all, there is nothing strikingly new in the Ogino-Knaus safe period. For at

least fifteen years I always taught that the week preceding menstruation is the practically sterile period. The Formulary that for three decades I sent out—gratuitously of course—to people asking for prevenceptive information, contained, besides formulas for jellies, suppositories, tablets, douches, etc., also the following paragraph:

. . . The week *preceding* menstruation is the *least* favorable. In fact, some claim that during the five or six days preceding menstruation, *every* woman is sterile. This is not so. But that conception during that time is *less likely* to take place is well established. And that *some* women are absolutely sterile in those days also seems to be a fact.

THE ABSOLUTELY "SAFE" PERIOD

Among the questions that one who is known to specialize in sexology receives almost daily, one of the most frequent ones is: Is there an absolutely safe period in the month, a period during which a woman *cannot* become pregnant (even if she should wish to), and if so, what time of the month is it? *YES!* And no. I know you are disappointed with the "no," but wait until I explain. There is a period in each menstrual month—the period of natural sterility—during which millions of women, the vast

majority of women, cannot conceive. But I do not wish to take the responsibility upon my shoulders of asserting with the aplomb of finality that this is the case with *all* women. In my professional experience I have learned not to make absolute assertions. The best rule has exceptions. Why there may be exceptions to the safe period rule, I'll explain later.

To come now to the kernel of the matter, the practical point which is no doubt of most interest to you. Which is the sterile period between the day of the onset of the menses and the next menstrual period? According to the latest researches of Prof. Ogino and Dr. Knaus, the month may be divided in three equal periods. Suppose a woman menstruates every 30 days—then the first (including the menstrual days) and the last ten days are sterile, the middle ten days fertile. If she begins to menstruate, say, October 1st, then from October 1st to October 10th she will be sterile, from October 11th to October 20th she will be fertile, and from October 21st to October 30th inclusive she will again be absolutely sterile. If a woman menstruates every 28 days, then the first and the last 9 days will be sterile, and the middle ten days will be fertile.

On what facts are these claims based? They are based on the following three facts which

may be considered scientifically well established. 1—Ovulation, that is, the discharge of the ovum from its Graafian follicle, takes place 12 to 16 days before the next menstruation. 2—The ovum (the little egg, or the mother-cell, as our prudes like to call it) can live only a few hours, at most a day, after it leaves the Graafian follicle, if it is not fertilized by a spermatozoon in the meantime. 3—The spermatozoa after being deposited in the woman's genital organs can remain alive only about forty-eight hours.

These facts being accepted as fairly well established, it follows that fertilization or impregnation can take place only in the mid-month period. Of course, I am not referring to the calendar mid-month, but to the menstrual mid-month. A woman who begins to menstruate on the 20th, her mid-month would be from the 1st to the 10th of the following month, et cetera.

This being the case, why do I not declare the periods I mentioned as sterile, with absolute definiteness? Why do I hesitate in spite of the fact that I know that people like and appreciate clear-cut, definite, unequivocal statements? For three reasons:

1—There are one billion women in this world, and while in the vast majority ovulation does take place 12 to 16 days before the next men-

struation, I am not at all sure that there may not be a certain percentage in whom ovulation takes place at a different period—perhaps six, perhaps twenty days before the next menstrual period.

2—I am not at all sure that *coitus itself*, particularly if the act is violently passionate, may not cause a super or extra-ovulation, i. e., the bursting of a Graafian follicle, and the discharge of an ovum before its time. We know very well—I know personally of several such cases—that coitus may under certain circumstances, into which I cannot enter here, provoke a premature menstruation. It therefore may quite likely provoke a premature discharge of the ovum. I am convinced that it may. And if this should happen, then the rhythm is spoiled, and conception may take place any time.

3—I do not wish a mother overburdened with too many children or an unmarried girl to rely too absolutely on the safe period, and then, if an accident should happen, come back at me with reproaches, because my advice got them into trouble.

With the above qualifications and exceptions, which from a practical point of view may be quite rare, but which must be counted with, you may take it as fairly well established that the first nine or ten and particularly the last nine

or ten days of the menstrual cycle are sterile days; while the middle ten days are the fertile days when conception is most likely to take place. That a woman—in order not to make mistakes—and some women are very forgetful—must keep strict track of the length of her menstrual cycle, of the first day of her menstruation, goes without saying. It is best marked on a small yearly calendar, which can be conveniently carried in the purse. Always mark the first and last day of the menstrual period. Also if you have mid-menstrual pain.—If asked if there is a difference between the cycle, I would state that the *last* third is the more sterile of the two. Decidedly so.

It is good to be familiar with the above facts; the knowledge is of value in many cases and may come in handy. But I do not wish you to consider this knowledge a prevenceptive Rock of Gibraltar.

Of course, the fact that the "safe period" is not safe in 100 per cent of all cases, which disadvantage it shares with chemical and mechanical prevenceptives, is its chief objection. But there are *several other* objections to it into a detailed discussion of which it is not necessary to enter here.

I will therefore conclude with the statement that I have made many times: that in spite of

the "safe period," there still remains, and probably will remain forever, an important field for chemical and mechanical prevenceptives, which, as they are being improved from year to year, will soon leave nothing to be desired.

THE WOMAN'S "SAFE PERIOD"—TWO REPORTS

I am now in receipt of two cases which corroborate my attitude on the Ogino-Knaus theory of woman's "safe period."

In one case, intercourse took place three days after the last day of menstruation and pregnancy resulted. In the second case, intercourse —the only one—took place five days before the expected menstruation and the result was pregnancy.

I repeat what I said before: I do not say that there is absolutely nothing to the theory, but to consider it absolutely safe and to make women believe so is most unfair. I feel like paraphrasing Cromwell's saying: "Trust in God and keep your powder dry." Trust in the Ogino-Knaus theory and have a prevenceptive jelly handy.