Birth Control for the British Working Classes

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Cambridge, Massachusetts

Historical Background of English Birth Control Clinics

For more than one hundred years England has had an organized birth control movement. No sooner had Malthus in the second edition of his notable "Essay"[1] suggested that the way out of the problem of over-population was "moral restraint"[2] than a select group of "Philosophical Radicals" and Utilitarian reformers objected to the solution of postponed marriage.[3] Francis Place, radical tailor of Charing Cross, friend of working men, counsellor to statesmen, and one of the most "solid-minded" and influential of nineteenth century reformers, brought to his point of view and gathered about him a

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* The data with which this article mainly deals were gathered in the course of a residence of fifteen months in England as a fellow of the Social Science Research Council, which body financed the research. In the study of the work of the clinics I was assisted by my wife. The North Kensington material under consideration here constitutes only a small part of the research now in progress on the clinical and historical aspects of birth control.

The authors wish to express their appreciation of the generosity of the officials of the North Kensington Clinic in opening their files for this study. That this coöperation required some independence of action is testified by the fact that the two largest London clinics, the Walworth Center and Dr. Stopes' clinic, have never permitted their records to be put at the disposal of independent investigators desiring to make quantitative analyses.

Special acknowledgment is due Dr. Louise Stevens Bryant, Executive Secretary of the [New York] Committee on Maternal Health, who criticized the manuscript, recast the tables, and furnished ideas for more effective graphic presentation. Dr. Bryant, with the coöperation of Dr. R. L. Dickinson, also prepared the footnote on medical indications for contraception. Much of whatever merit this paper may have is due Dr. Bryant; for its shortcomings the authors alone are responsible.—*Norman E. Himes.*

number of ardent workers in the cause. One can scarcely do more here than mention their names. His most immediate disciple was Richard Carlile, stalwart warrior in the fight for the freedom of the press, whose unbounded enthusiasm carried him to excessive lengths in championing the new program.[4] Place, through his disciples in America, Robert Dale Owen and Dr. Charles Knowlton, was influential in founding the American birth control movement which began in this country in 1828.

In the century of agitation in England the outstanding figures (other than those already mentioned) are Dr. George Drysdale (the "Doctor of Medicine" who wrote "The Elements of Social Science"), the anonymous "Anti-Marcus," the able lawyer Charles Bradlaugh, and the energetic and eloquent Annie Besant. These and many other pioneers, working with precious little public support and much opposition, have done much to bring to the working classes reliable knowledge by which the so-called "lower orders" might control the frequency and the time of birth of their offspring.

With the approach of the latter part of the century general interest in the subject widens, and in the first three decades of the twentieth, it gradually dawns on the leaders of the Church that the people have determined quite among and by themselves that they will no longer be mystified. The medical profession, urged from within by the more far-seeing leaders of the healing art, and impelled from without by the pressure of a gradually but definitely crystallizing public opinion, begins to inform itself lest the function of furnishing contraceptive advice be taken entirely out of its hands by laymen. The medical periodicals begin to look with sympathy upon what they used to view before with haughty detachment.

The newspapers start debating the subject to the tune of hundreds of columns each week. The topic vies with the Prayer Book dispute in claiming public attention. Men and women of social and intellectual standing, who once discussed the subject in furtive whispers, now mount the rostrum and let their views be known with unabashed fortitude. Government officials and influential private citizens begin to see the relation between the problems of the birth rate and the welfare and prosperity of the state.[5] The National Council of Public Morals, a strictly voluntary body of thoughtful, public-spirited citizens, institutes the National Birth Rate Commission (a unique institution) with its subsequent committees investigat-

ing the ethical, the medical—and we hope shortly, the economic—aspects of birth control.[6]

The countryside is inundated with a flood of literature, some of it useful, most of it trashy and perhaps even harmful. Since the war it has been calculated that not less than fifteen million books, pamphlets and brochures furnishing practical contraceptive advice (or stating where it can easily be obtained) have been circulated in England. This figure does not include newspaper or magazine advertising.

In England the sources which are bringing about the diffusion of contraceptive information among various social classes have been operating for more than one hundred years. However, the dates 1877 (when Bradlaugh and Besant were prosecuted for publishing the Knowlton pamphlet) and 1921 are important landmarks in the concerted, organized attempts to get this information to working class mothers. The propaganda of 1823 led by Francis Place was relatively ineffective so far as immediate results were concerned. Although much was attempted before 1921 in behalf of the working classes, the clinics opened up a new period in the history of the movement aiming at the emancipation of women from their slavery to the reproductive function.

The First Clinic. The first birth control clinic in the British Empire (but not the first in the world) was opened by Dr. Marie C. Stopes (in private life Mrs. H. V. Roe) in March, 1921, at 61 Marlboro Road, Holloway, London, N. 19.[7] In the years 1917-18, when attempts were being made to interest others in opening a birth control clinic—large numbers of hospitals had consistently refused such information to their patients—Mr. H. V. Roe offered a guaranteed annual income of £1,000 for five years, and £12,000 in his will to an English hospital on condition that it set in operation at once a birth control and maternity clinic.[8] The committee of the hospital approached, refused the offer. In Dr. Stopes' work "The First Five Thousand," and in her biography by Aylmer Maude there is related the origin of Dr. Stopes' own interest in the subject. She believed that to the educated and well-to-do contraceptive information was readily available—there never has been any specific, restrictive legislation in England—but that to the poorer classes, unable or reluctant to pay the necessary fees, this advice was relatively inaccessible. Dr. Stopes and her husband, therefore, opened "The Mothers Clinic" where more than ten thousand cases have now been advised. The

clinic is open each week-day for free advice from the nurses and mid-wives in attendance. It also has the services of a trained woman consulting physician one afternoon a week. Otherwise it is without immediate medical supervision, Dr. Stopes not being a physician.

Later Clinics. Before Dr. Stopes opened her clinic, Dr. and Mrs. C. V. Drysdale, the former for many years president of the Malthusian League (founded in 1879 as a consequence of the Bradlaugh-Besant trial), had plans for opening a similar clinic. For reasons which need not be detailed here their plans were delayed and the Walworth Women's Welfare Center at 153A East Street, Walworth Road, London S. E. 17 was not opened in the poor district about Walworth Road until November, 1921, nine months after Dr. Stopes had opened her clinic. For a short period this clinic was more or less under the guidance of its sponsors, the officials of the Malthusian League. The fact that Dr. Norman Haire, the Harley Street gynecological specialist was in charge (assisted by trained nurses) made this the first English clinic under medical direction. Substantial assistance was received from Mr. John Sumner, a Birmingham manufacturer, whose liberal gifts to the Birmingham clinic and to the Malthusian League have furthered similar work in other quarters. After the Walworth Center was well under way, the Drysdales and the Malthusian League dropped out and control was turned over to a new group calling itself the Society for the Provision of Birth Control Clinics.

Since this organization was founded, two other clinics have been opened in London: the East London Women's Welfare Center, and the North Kensington Women's Welfare Center. Similar birth control clinics have been opened by interested voluntary groups in two university towns, Cambridge and Oxford, in industrial centers like Birmingham, Wolverhampton, Manchester, and Liverpool. Scotland has similar centers operating at Glasgow and Aberdeen. In several instances the Society for the Provision of Birth Control Clinics has been influential in the formation of these local groups, following this up by assisting in problems of organization, administration, and finance. At Walworth, physicians and nurses from the provincial centers have been trained in the technique—which differs somewhat from that taught at the Mothers' Clinic run by Dr. Stopes. In addition to such clinics operated by responsible voluntary groups, advice is furnished by a few hospitals and regular dispensaries.[9] There are also a large number of so-called private birth control

clinics in charge of nurses and mid-wives throughout the United Kingdom. But these "clinics," being managed by individuals, partly at least for private profit, are on a somewhat different footing.

North Kensington Clinic

The North Kensington Women's Welfare Center—the clinic whose records form the basis of this study—was opened in November, 1924 at 12 Telford Road, Ladbroke Grove, London, W. 10. Although Kensington is one of the most wealthy sections of London it is not without a poor, over-crowded, inadequately-housed section. It was in such a locality that those responsible for the initiation of the clinic decided to open it. Like all other British institutions of its kind it is dependent entirely upon voluntary contributions, the patients' small fees being entirely inadequate for its support. The consultation fee of one shilling, payable on the first visit, is not collected on the subsequent visits so that the total fees, plus whatever small profit there may be in the sale of appliances, constitutes only a very small proportion of the total income. It has received no support whatever from the government. The hours of attendance are Mondays, 3-4 p. m., and Tuesdays, 6:30-8 p. m.

When the clinic was first opened very few women came, as was expected; for in the absence of extensive propaganda it necessarily takes time for the community to realize that such a center has been opened in its midst. North Kensington's first clinic report states that when the center first opened mothers were "much too shy; they didn't know what would happen, but gradually more and more came, at first in the evenings, when it seemed easier to slip in and out. Then they found that after all it was not so alarming." In the first nine months 255 women had come for advice, and 196 had already returned for their second visit. The North Kensington Center thus received substantial recognition from the beginning, if its record is to be compared with that of similar institutions.

Clinic Procedure. The patient enters a fairly attractive waiting room, is called into the office of the representative of the clinic, usually a volunteer, who takes down on one side of a large filing card the answers to a few simple but necessary questions (See Forms 1A and 1B). The questioner usually finds little difficulty in securing the required response. The patient then takes her card to the woman physician in attendance upstairs who fills in the details of the medical history. This is followed by a pelvic examination, after which the

patient is fitted with the proper size of appliance. The clients receive "as much time and skill and patience as if they were private patients." The nurse then sees that the client is properly instructed in the use of the appliance, the patient trying and retrying until she learns its proper use. A printed card of instructions (Forms 2A and 2B) is then handed to the patient who buys her supplies at cost, i.e., at a little more than wholesale price.

The fact is impressed upon her that no methods are fool-proof, that she has her own responsibility in the technique, and that the clinic must have her sincere coöperation, particularly in the matter of follow-up. It is of basic importance that the patient be convinced of the necessity of returning within a week and again within six months. We shall see later the extent to which these instructions are carried out. After receiving full instructions and purchasing her supplies the patient returns her record card to the attendant downstairs. It is filed according to number after the patient's instruction card (See Forms 2A and 2B) is correspondingly numbered. An alphabetical file of patients' names is also kept with number cross-references.

Results of Study of Case Histories

Source and Character of Data. Through the coöperation of the executive committee of the North Kensington Women's Welfare Center, who were the first body to open their files to this investigation, it is possible to present the data on the first thousand cases to visit this clinic. The cases here summarized range in number from 1 to 1006 inclusive, since it was necessary to discard certain records due to incomplete information; or because of individual variations which made it seem likely that a bias, even minor in nature, might be introduced into the summary figures. In one or two instances the patient was married twice and it was impossible to determine the exact number of years spent in the marital state. The records of three single women were discarded because they did not receive the advice usually given to applicants.

This report naturally falls into two main divisions. The first deals with a simple statistical summary of the facts of the first thousand records, the second part with a follow-up study of some one hundred cases made through home visits.

Limitations of Data. Certain limitations of the data need to be observed. The feeling seems to be quite general among the officials

FORM 1-A (Face, Clinic Record Card).

Date ..... No.....

NORTH KENSINGTON WOMEN'S WELFARE CENTRE
12 Telford Road, W. 11

Name .....

Address .....

.....

Heard of Centre from .....

Date of Marriage .....Wife's Age .....Husband's Age .....

Husband's Occupation .....Wages .....

Pregnancies ....Born alive ....Born dead ....Miscarriages ...Alive now ...

Health of Children .....

Date	Born Alive	Born Dead	Miscarriage	Age at Death	Cause of Death or Miscarriage
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

FORM 1-B (Reverse, Clinic Record Card).

Date General Condition

Bowels Micturition Periods Loss

Dysmenorrhea Dyspareunia Last Menstrual Period

On Examination Vulva Perineum Cervix

Uterus Tubes Ovaries No. [size] of —— [Appliance]

Date	How —— is fitted by Patient, etc.	Visit or Letter for New Appliance	Letter sent

FORM 2-A *(Face, Patient's Instruction Card).

N. KENSINGTON WOMEN'S WELFARE CENTRE
12 Telford Road, Ladbroke Grove, W. 10

SESSIONS—MONDAYS, 3—4 p.m.
TUESDAYS, 6.30—8 p.m.

Name .....

No. .....

(1) Please return in a week's time, so that the doctor can tell you if you are using the appliance correctly.
(2) Never leave the —— in for more than 12 hours.
(3) Always smear the —— with ointment before use.
(4) Syringe before you take the —— out, and after you take the —— out, with warm soapy water.
(5) Wash —— after use, dry it, and powder it with French chalk. Keep syringe clean.
(6) The ——, when new, is round, but tends to get out of shape. Gently press into a round shape before use.
(7) It is very important to avoid constipation.
(8) Appliances can be sent by post. If writing to us, please mention the number on your card.
(9) Come back every six months if you can. Your —— may need renewing.

*[Underlined words in red].

FORM 2-B (Reverse, Patient's Instruction Card).

ADVICE ON CONSTIPATION

Constipation must be avoided. Much ill-health is directly due to this.

A regular habit at the same time every day is most important.

Any one of the following aperients is good:—

Senna Pods—4 to 15 daily. 6d. an oz.
(The pods should be soaked in cold water for 8 hours, and the water taken at night.)

Liquid Extract of Cascara—10 to 60 drops daily.

Epsom or Glauber salts—1 to 2 teaspoonfuls daily.

Medicinal Liquid Paraffin—1 tablespoonful daily. 8 oz. 1/6.

THE FOLLOWING DIET HINTS ARE USEFUL

Drink plenty of water.

Eat brown or wholemeal bread instead of white.

Cooked, or better, raw fruit (oranges, apples, prunes, figs), and salads.

Vegetables of all kinds. Porridge.

Eat slowly and chew thoroughly.

of English clinics that detailed and accurate records are not of paramount importance. The records of the North Kensington center are kept as well as those of any of the other English clinics. The main reason why the record forms are not more elaborate is a strong feeling among the directors of the clinic that further questioning of the clients might unduly embarrass them or even reduce attendance. And since it has always been considered the major purpose of the center to give the poor classes access to information heretofore readily available only to those of more initiative and higher economic status, it has been felt desirable to limit questioning. In the last year or two, however, there has been a move away from this tendency to gather only meager data and an increasing desire to collect more complete information. This is particularly reflected in a new research committee[10] now coöperating with the North Kensington center. Their case card is much more elaborate[11] than that which has been heretofore used either at North Kensington or at any of the birth control centers.

The information gathered is further limited by the patients' own knowledge. In the summaries which follow, for example, the figures on wages are unreliable; the patient often does not know how much

her husband earns, merely how much she receives each week on which to run the household. Sometimes it is difficult for mothers of large families to remember how many pregnancies they have had. Still more frequently they are unable to account accurately for what is here called pregnancy losses, that is, the difference, after allowance has been made for twins, between the number of pregnancies and the number of living children at the time of the mothers' first visits. Since some pregnancies were unaccounted for on the records, the exact type of loss (See Table I) is unknown. The same difficulty was characteristic of all the other clinics, and North Kensington stood up comparatively well in relation to the others. The limitations in other series of data will be noticed as each series is considered.

TABLE I

PREGNANCIES AND RESULTS REPORTED BY 1,000 WOMEN SEEKING BIRTH CONTROL ADVICE AT NORTH KENSINGTON CLINIC

	Pregnancies		Per cent of losses
	Number	Per cent	
Total pregnancies	3,855	100	
Cases of twins	36	1	
Total living children [a]	3,005	78	
Total losses	886	23[b]	100
Abortions [c]	460	12	52
(Abortions recorded as induced)	(65)	(2)	(7)
Still-births	72	2	8
Post natal deaths [d]	295	8	33
Type unknown	59	1	7

a. Children living at the time of the mothers' first visits. Families incomplete with few exceptions.

b. Since the figure "total losses" (886) includes the losses of the second child in cases of twins, the percentage, calculated on a basis of pregnancies, is 23 instead of 22, bringing the total percentage to one point higher than one-hundred per cent.

c. These losses were classed by all the English clinics as "miscarriages" except those known to have been self-induced, for which group the term "abortion" was retained. This seems to be in accordance with *lay* usage, but Dr. Louse Stevens Bryant of the Committee on Maternal Health advises that this is not the best present medical usage. Any expulsion before viability is now considered an abortion, classification being subdivided into *induced*, *accidental*, and *spontaneous*. Only the first of these carries with it any crim-

Another reason for the fact that our data are not as elaborate as one might wish is to be found in the fact that this clinic, like all birth control clinics, is a comparatively new institution. Further, there has been what we believe to be a mistaken notion that patients are reluctant to answer questions in relation to their sex history and experience. There are many sound reasons for believing that this is not borne out by experience. Every psychiatric and hospital social service worker in America weekly gathers data which many English clinic officials believe it impossible to secure. Some American (notably New York) clinics gather quite complete sex histories.

inal implication, and then only under circumstances which vary in different localities. While the authors have adopted this newer terminology (since it seems to be in accordance with the weight of authority) they cannot help feeling that it is, in a sense, misleading and incomplete. For example, to medical persons the term "induced abortion" undoubtedly carries the dominant connotation of a delivery made by physicians under modern aseptic conditions, after consultation with at least one colleague and upon substantial medical indication, yet not one induced abortion in a hundred—perhaps not one in a thousand—is produced under these conditions. Preferably the term induced abortion should be further subdivided into (a) therapeutic, those done by a physician under the conditions outlined and (b) all others, whether by physician or laymen. In most countries all others would be illegal. The figures at North Kensington, however, do not permit of such refinement. We think it well, none the less, to bear this classification in mind for future study.

Objections can likewise be raised against the medical sub-classification of "accidental abortion." Suppose a woman with an unwanted pregnancy repeatedly jumps from a table; perhaps she is successful in inducing an abortion or miscarriage. Since it had more serious consequences than she contemplated she consults her physician who, refusing to sit in judgment on the woman's intent, or being, indeed, totally ignorant of it, considers the abortion "accidental." Obviously it is nothing of the kind.

The difficulty of determining when abortions are genuinely "spontaneous" is not to be minimized. While it may be a convenient term to apply to those cases where the cause is unknown—as one speaks of a fire being caused by "spontaneous combustion"—it should be remembered that there is a cause even if we are unable to detect it. And if the sub-classification now accepted by the weight of authority aims to classify abortion on a causative basis, it is seriously defective. In working out new classifications for the study of this phenomenon we would suggest the urgency of considering such a psychological factor as the patient's *intent* along with the physiological aspects of the act itself. The law has, for example, always considered the *intent* in committing an overt act as of almost equal importance (in determining guilt) as the commission of the act itself. In the study of the causative factors in abortion, if our classification is to be based upon this, it would seem that medical science could advantageously draw a similar distinction.

d. From the data available it is impossible to separate deaths occurring within the first few months and within the first year from those occurring later but prior to the mother's first visit to the clinic—as desirable as such a classification would be. Therefore, the term "post natal deaths" means, whatever it may imply in studies of infant mortality, deaths occurring after birth and prior to the mother's first visit to the clinic.

I. Findings from Case Records

The items on the case records susceptible to tabulation fall under the headings of obstetrical history, with number of pregnancies and their results (Tables I-VI); the number of years married and the ages of husband and wife (VII, VIII); the husband's occupation (IX). The reasons for refusing treatment, and the results reported on follow-up are presented as summaries in the text.

Pregnancies and Their Results. The first item of interest is the obstetrical history of these patients. As shown in Table II, among the thousand women, 957 reported from one to fourteen pregnancies, and 43 had never been pregnant. There were a total of 3,855 pregnancies or nearly four apiece. This is important as showing that the clinic is not visited by women seeking to evade their "natural" responsibilities.

Referring again to Table I, it will be seen that, since there were 3,855 pregnancies and 36 twins (roughly one per cent. of the pregnancies), the *expected* number of live births was 3,891. However, owing to various types of losses before maternity only 3,345 foetuses, according to the records of the clinic, resulted in live births. After allowing for various losses there is a discrepancy between the total number of children born alive as recorded by the clinic and the number actually born alive as deduced by allowing for these losses. This is partly to be accounted for by the fact that it could not be determined from the clinic records in just what type of loss 59 pregnancies resulted. But by a process which need not be detailed here, it has been estimated that probably 18 pregnancies resulted in still-births or accidental or spontaneous abortions and 41 in post natal deaths. Deducting the total number of children now living from the *expected* number of live issue (3,891) there is a pregnancy loss of 886, or 23 per cent. of the total number of pregnancies.

Pregnancy Losses. It is a striking fact that in this series 52 per cent. of all the pregnancy losses were due to abortions of some type (See footnote to Table I). Seven per cent., or one in 14, are definitely known to have been induced, undoubtedly self-induced. Figured on the basis of all *pregnancies* the waste due to abortions is of course much smaller—12 per cent. for abortions of all classes, 2 per cent. for those known to have been induced. That the percentage of losses due to abortions (7 per cent.) is far below the actual figure

is certain. The clinic staff do not press patients for this information; the induction of abortion is not a fact which women readily admit, at least to strangers. For these reasons a certain number of unclassified abortions should undoubtedly be listed as self-induced. Clients very often come to the clinic with the hope that the doctor will interrupt a pregnancy. Not a week and hardly a day passes but that some patient comes to the clinic for this purpose. As we shall see later, pregnancy or suspected pregnancy is the chief reason why patients are turned away unfitted after their first visit. This subject is dealt with more extensively below.

The singular fact about this table of losses (Table I) is that the abortion percentage (52), far exceeds the percentage of losses resulting from both still-births and general deaths (41 per cent.). In so far as this group is representative of the rather poor mothers of the English nation, and in so far as this fact is borne out by the experience of other clinics distributed throughout England and Scotland, it is a social fact of first-rate importance. Moreover, it is a fact which is emerging alone from the records of the birth control clinics. It will be found in no census returns. Its significance is in demonstrating the one-sided emphasis now current in focussing upon infant mortality alone rather than viewing the problems of maternity as a whole; rather than directing attention to the essential relation between the human effort and sacrifices expended in undergoing pregnancies (i.e., the "costs" physical, social, and economic) and the results achieved by way of obtaining the birth of live children, and if possible bringing them to maturity.

Analysis of Results. The source figures for the most important of the obstetrical data are given in Table II, which is divided into three parts as follows: Part A shows the total number of women reporting each number of pregnancies, from none to fourteen, the total pregnancies in each order, the number of living children surviving at the time of the first visit, and the number of losses of various kinds, by abortion, stillbirth, deaths, and undetermined causes. Part B shows the distribution by per cent. of these various totals through the different orders. Part C shows the proportion of each order of pregnancy surviving or lost in the various ways.

Increase of Losses with Frequency of Pregnancy. A steady increase in per cent. of losses is shown in Part C as one descends the column from the lower to higher frequency orders. Conversely the proportion of survivals decreases. There is some irregularity in both

TABLE II

ANALYSIS OF RESULTS ACCORDING TO NUMBER OF PREGNANCIES REPORTED

A. Total pregnancies, living children and losses

Number of pregnancies	Total		Living children			Losses				
	Women	Pregnancies	Total	Twin births	Minus twins	Total	Deaths	Still-births	Abortions	Cause unknown
Total	1000	3,855	3,005	36	2,969	886	295	72	460	59
None	43	0	0	0	0	0	0	0	0	0
One	151	151	147	6	141	10	2	0	8	0
Two	187	374	337	4	333	41	11	9	20	1
Three	173	519	436	2	434	85	32	4	46	3
Four	130	520	398	6	392	128	35	10	77	6
Five	91	455	360	5	355	100	27	10	57	6
Six	72	432	334	2	332	100	33	3	50	14
Seven	36	252	171	2	169	83	22	9	49	3
Eight	31	248	196	1	195	53	25	2	24	2
Nine	29	261	188	2	186	75	23	7	36	9
Ten	18	180	129	1	128	52	18	2	28	4
Eleven	18	198	130	4	126	72	31	7	29	5
Twelve	11	132	79	1	78	54	24	9	16	5
Thirteen	7	91	64	0	64	27	11	0	15	1
Fourteen	3	42	36	0	36	6	1	0	5	0

TABLE II (Continued)

B. Distribution of results by per cent of instances

Number of pregnancies	Total		Living children [a]	Losses				
	Women	Pregnancies		Total	Deaths	Still-births	Abortions	Cause unknown
Total	100	100	100	100	100	100	100	100
None	4	0	0	0	0	0	0	0
One	15	4	5	1	0.7	0	2	0
Two	19	10	11	5	4	13	5	2
Three	17	13	15	10	11	5	10	5
Four	13	14	13	14	12	14	17	10
Five	9	12	12	11	9	14	12	10
Six	7	11	11	11	11	4	11	23
Seven	4	7	6	9	7	13	10	5
Eight	3	6	7	6	8	3	6	3
Nine	3	7	6	9	8	9	8	15
Ten	2	5	4	6	6	3	6	7
Eleven	2	5	4	8	11	9	6	9
Twelve	1	3	3	6	8	13	3	9
Thirteen	0.7	2	2	3	4	0	3	2
Fourteen	0.3	1	1	1	0.3	0	1	0

a. Corrected for twins.

TABLE II (Continued)

C. Distribution of results by per cent of pregnancies

Number of pregnancies	Total Pregnancies	Living children [a]	Losses				
			Total	Deaths	Still-births	Abortions	Cause unknown
Total	100	77	23	8	2	12	1
None	0	0	0	0	0	0	0
One	100	93	7	2	0	5	0
Two	100	89	11	3	2	5	1
Three	100	84	15	6	1	9	1
Four	100	75	25	7	2	15	1
Five	100	78	22	6	2	13	1
Six	100	77	23	7	1	12	3
Seven	100	67	33	9	3	20	1
Eight	100	79	21	10	1	9	1
Nine	100	71	29	9	3	14	3
Ten	100	71	29	10	1	16	2
Eleven	100	64	36	16	3	15	2
Twelve	100	59	41	18	7	12	4
Thirteen	100	70	30	12	0	17	1
Fourteen	100	86	14	2	0	12	0

a. Corrected for twins.

instances in the last two orders owing to the small numbers and the presence of some exceptionally healthy families. The tendency to increasing rate of loss is shown more clearly in Table III where the figures for results in the various orders of pregnancies have been grouped into four groups as follows: (1) those with none, one and two pregnancies; (2) those with three; (3) those with four and five; and (4) those with six to fourteen. These groups were determined by adding the numbers of women in the whole series and finding where the first quartile, the second quartile or median, and the third quartile points came and assigning all having the number of pregnancies included between these various points in the same group.

The figures are shown graphically in Figure A, where it may be noted that Group 1, including 38 per cent. of the women with not over two pregnancies, had 14 per cent. of the pregnancies, 16 per cent. of the survivals and only 5 per cent. of the losses, whereas Group 4, the 23 per cent. at the other extreme with six to fourteen pregnancies, had 59 per cent. of the losses.

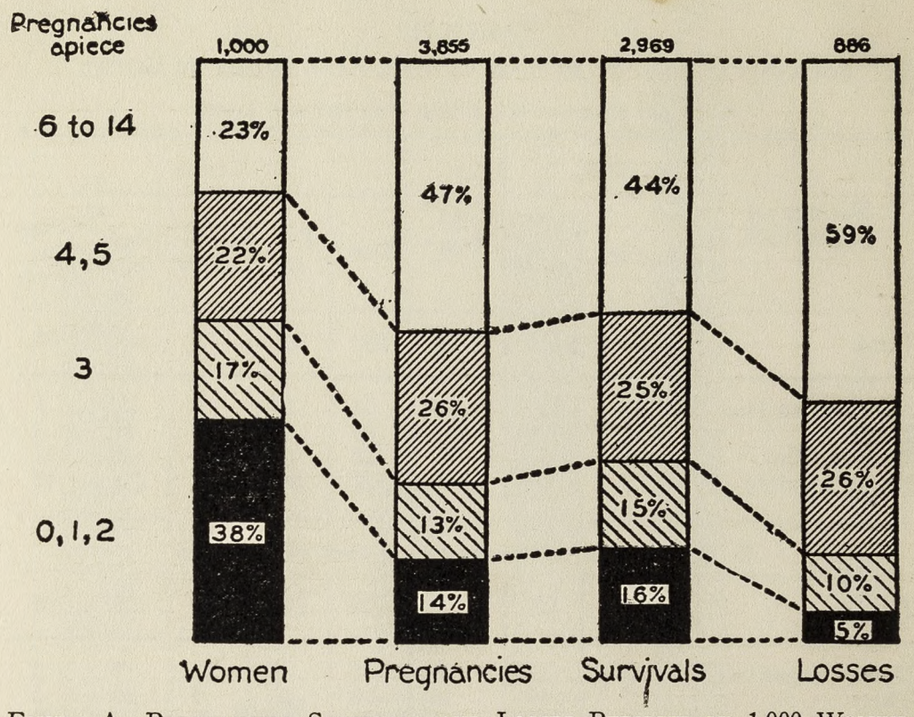

FIGURE A—PREGNANCIES SURVIVALS AND LOSSES REPORTED BY 1,000 WOMEN SEEKING BIRTH CONTROL ADVICE

In Table III it will be noted that the total losses in Group 1 were 51; in Group 2 they were 85; in Group 3 they were 228; and in Group 4 they were 522. The per cent. lost in each group is shown graphically in Figure B, which also shows the proportion of abortions. However, despite the very high *rate* of loss in the third and fourth groups, these show the largest number of survivals, illustrating "Nature's way" of insuring continuance of the species. In Table III and in Figure B, it will be noted that 10 per cent. of the pregnancies in Group 1 resulted in losses, and 16 per cent. of Group 2, while 24 per cent. of Group 3, and 28 per cent. of Group 4, were lost. Conversely, in the first group, 90 per cent. of the pregnancies resulted in living children; in the second group 84 per cent. of the pregnancies resulted in living children; in the third group 76 per cent. of the pregnancies resulted in living children; while in the fourth group only 72 per cent. resulted in children who were living at the time the mother first visited the clinic.

While it cannot be deduced from this table, it may be stated that the women in the series studied who had 12 pregnancies, experienced a rate of loss six times as great as the patients who had only one

TABLE III

ANALYSIS OF RESULTS IN VARIOUS PREGNANCY ORDERS BY GROUPS

A. Total pregnancies, living children and losses

Number of pregnancies	Total		Living children [a]	Losses				
	Women	Pregnancies		Total	Deaths	Stillbirths	Abortions	Cause unknown
Total	1,000	3,855	2,969	886	295	72	460	59
None, one and two	381	525	474	51	13	9	28	1
Three	173	519	434	85	32	4	46	3
Four and five	221	975	747	228	62	20	134	12
Six to fourteen	225	1,836	1,314	522	188	39	252	43

B. Distribution of results by per cent of instances

Total	100	100	100	100	100	100	100	100
None, one and two	38	14	16	5	5	13	7	2
Three	17	13	15	10	10	5	10	5
Four and five	22	26	25	26	21	28	29	20
Six to fourteen	23	47	44	59	64	54	54	73

C. Distribution of results by per cent of pregnancies

Total		100	77	23	8	2	12	1
None, one and two		100	90	10	3	2	5	—
Three		100	84	16	7	1	8	—
Four and five		100	76	24	8	1	14	1
Six to fourteen		100	72	28	10	2	14	2

a. Corrected for twins.

pregnancy. After the third pregnancy, the rate of loss is high—the rate ranging from 21 per cent. to the maximum of 41 per cent. The peak rate of loss was reached in the twelfth order, while the group that had only one pregnancy had the smallest rate, despite the extra hazards of first births.

The third, fourth, fifth, and sixth pregnancy orders furnished 50 per cent. of the total number of pregnancies and 13.6 per cent. were provided by the first and second order pregnancies. Sixty-two per cent. of the total number of living children were provided by the second to sixth order pregnancies, inclusive.

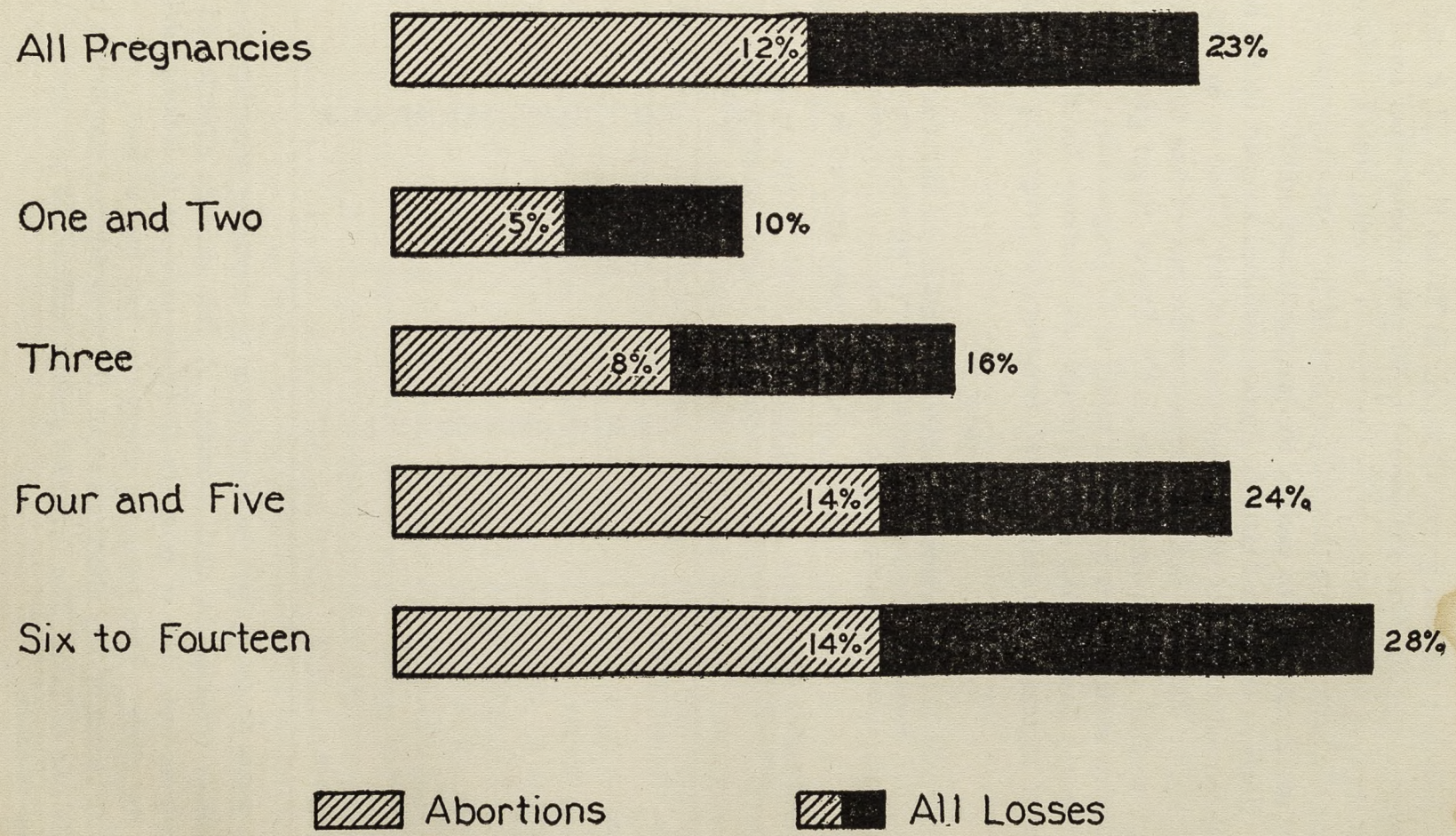

FIGURE B—PERCENTAGE OF LOSSES FROM ALL CAUSES AND BY ABORTION ACCORDING TO NUMBER OF PREGNANCIES

Although the data do not all appear in Tables II or III, it may be observed that the first and second order pregnancies experienced six per cent. of the abortions, while the third to seventh orders, inclusive, bore the brunt of more than 60 per cent. of this type of loss, an average of 12 per cent. for each of the last mentioned orders.

Early in 1925 Dr. Marie C. Stopes published a report on the first five thousand patients that visited the Mothers' Clinic up to August 31, 1924. Table IV is a comparison of the rate of loss in the series here studied and the rate of loss in Dr. Stopes' larger group which included some women having as many as 17 pregnancies. Both sets of figures illustrate the same principle: the tendency for the rate of loss to increase with an increased frequency of pregnancy.

TABLE IV

RATES OF LOSS ACCORDING TO NUMBER OF PREGNANCIES REPORTED IN TWO SERIES OF PATIENTS ATTENDING BIRTH CONTROL CLINICS

Number of pregnancies	Per cent losses reported in	
	North Kensington series of 957	Dr. Stopes' series of 4,235
One, two and three	11	10
Four	25	18
Five	22	22
Six	23	22
Seven	33	27
Eight	21	26
Nine	29	29
Ten	29	33
Eleven	36	28
Twelve	41	37
Thirteen	30	36
Fourteen	14	29
Fifteen	—	40
Sixteen	—	25
Seventeen	—	50

Table V deals with the distribution of abortions according to the number reported by each woman. A few patients experienced as many as four, five, or even six abortions previous to seeking advice, at the clinic. Two hundred ninety-two had had at least one. Of those reporting any abortions at all, the preponderant proportion had only one or two. The first two groups suffered 68 per cent. of the total number.

TABLE V

DISTRIBUTION OF ABORTIONS ACCORDING TO FREQUENCY

Number of abortions	Women		Abortions	
	Number	Per cent	Number	Per cent
Total	292	100	460	100
One	187	54	187	41
Two	62	21	124	27
Three	27	9	81	18
Four	13	5	52	11
Five	2	1	10	2
Six	1	0.3	6	1

Size of Family. Up to the time of visiting the clinic for the first time the patients had on the average 3.86 pregnancies and 3.00 living children. Reference to Table II, A, and to Figure C will show that the mode for both pregnancies and living children is two. Those who had a larger number of pregnancies and children brought the arithmetic means considerably over the modal numbers. Roughly speaking, it may be said that the clinic patients had undergone, on the average, nearly four pregnancies each, and that they now have, on the average, three living children.

These families are much smaller than one is often led to believe representative of those who seek advice of birth control clinics. There were a few large families. On the other hand, 43 cases had had no pregnancies at the time of coming to the clinic. This last group had, however, been married only 2.93 years; if one case (possibly sterile), married 22 years, is omitted, the no pregnancy order averaged only 1.42 years in the marital state. When the relevant facts pertaining to the group as a whole are taken into consideration it will be seen that the families are not small. Moreover the clinic families are far from being completed families. The mode (Figure D) for the distribution of years married is at six years, with other peaks at two years and ten years, the simple arithmetic mean being 8.7 years. Details are shown in Table VII.

Ages. The greatest number of patients come under the age group 26-30 years as shown in Figure E and Table VIII. The same holds true of the clients' husbands. The arithmetic means were,

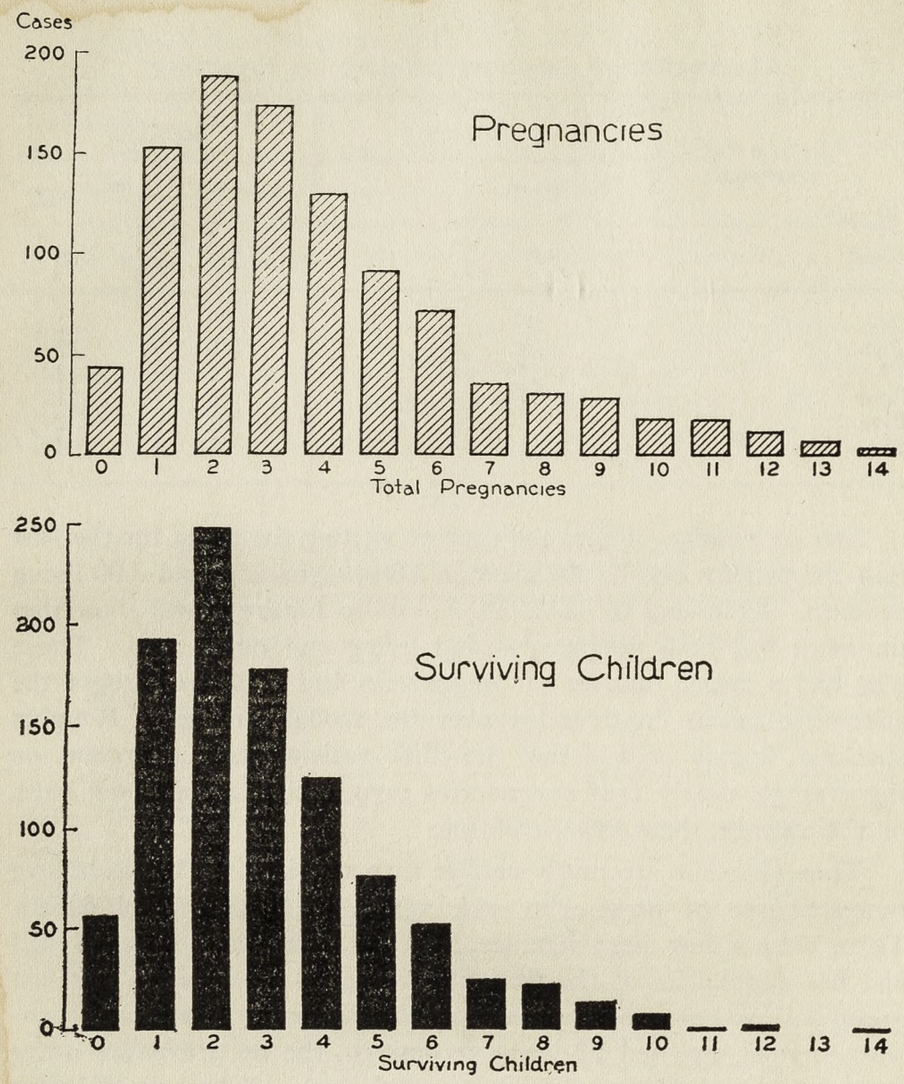

FIGURE C—NUMBER OF PREGNANCIES AND LIVING CHILDREN REPORTED BY 1,000 WOMEN

however, higher; for men it was 33.9 years; for the clients 31.3 years. The patients had a reasonable number of children, therefore, despite the fact that they had been on the average only eight and a half years in the marital state. The average number of pregnancies and the average number of living children is somewhat larger among the patients attending certain clinics outside of London. Comparison may be made by consulting a table which one of the authors has published elsewhere.[12]

TABLE VI

DISTRIBUTION OF LIVING CHILDREN ACCORDING TO NUMBER PER WOMAN

Number of living children	Women	Children	
		Number	Per cent
Total	1000	3,005	100
None	56	0	0
One	193	193	6
Two	248	496	16
Three	179	537	18
Four	125	500	17
Five	76	380	13
Six	52	312	10
Seven	25	175	6
Eight	22	176	6
Nine	13	117	4
Ten	7	70	2
Eleven	1	11	0.4
Twelve	2	24	1
Thirteen	0	0	0
Fourteen	1	14	0.5

TABLE VII

YEARS MARRIED BEFORE SEEKING BIRTH CONTROL ADVICE AT CLINIC

Years married	Number reported		Years married	Number reported	
	Couples	Cumulative		Couples	Cumulative
Less than one	22	22	Fifteen	42	861
One	61	83	Sixteen	20	881
Two	67	150	Seventeen	22	903
Three	56	206	Eighteen	14	917
Four	70	276	Nineteen	20	937
Five	75	351	Twenty	26	963
Six	85	436	Twenty-one	6	969
Seven	62	498	Twenty-two	7	976
Eight	56	554	Twenty-three	6	982
Nine	41	595	Twenty-four	4	986
Ten	62	657	Twenty-five	4	990
Eleven	50	707	Twenty-six	4	994
Twelve	36	743	Twenty-seven	4	998
Thirteen	40	783	Twenty-eight	2	1000
Fourteen	36	819			

The smaller number of living children among the patients in this series may be due to higher living costs in London, to scarcer hous-

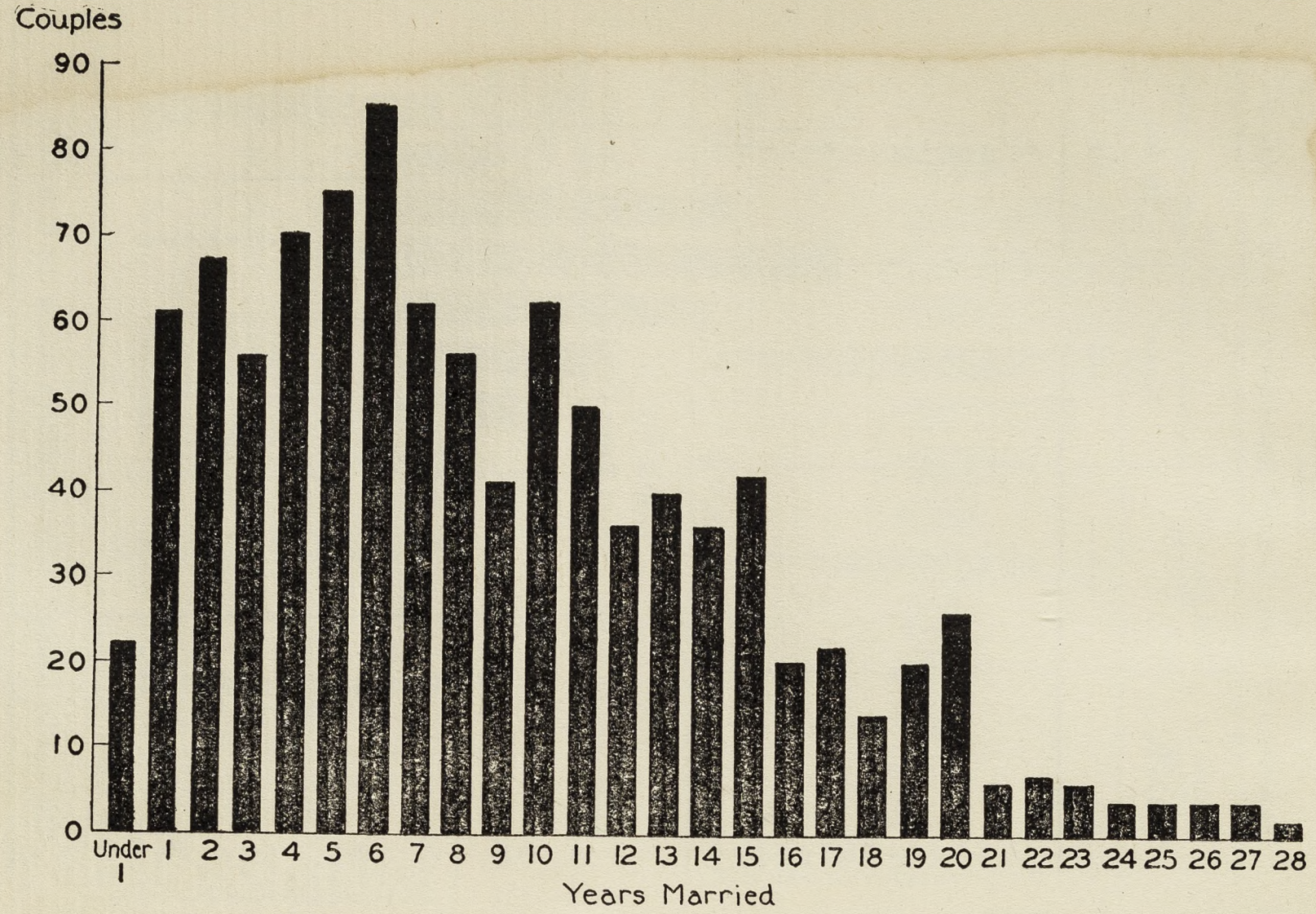

FIGURE D—YEARS COUPLES SEEKING BIRTH CONTROL ADVICE HAD BEEN MARRIED

ing, and to factors associated with urbanization, such as the ease of communication of birth control information. Whether this group previously used contraceptives to a greater extent than the patients visiting some other clinics is unknown. It is doubtful whether this factor is important. Whether or not these patients have previously employed contraceptive measures was not inquired into when these data were recorded. Dr. Stopes found that *coitus interruptus* prevailed in her cases.[13] It is usually ineffective as a method of limiting the size of the family. If, therefore, it was used to any great extent by the patients in our series, its general effectiveness in producing the result mentioned above is extremely doubtful.

There is a widespread notion that the clinics deal mainly with patients who have had excessively large families. The officials of such centers are themselves responsible for the currency of this opinion. They have sometimes published the details of extreme cases as representative of those with which they deal. This unintentional misrepresentation is unfortunate. On the other hand the position is not tenable that contraceptive advice should be given only to those who have had three or four children. This overlooks the cases in which contraception may be medically indicated[14] even in cases where the patient may have borne no children at all. Then too, the clinic has no more the right than the medical profession to set itself up as the censor of the conduct of others. What it dare not say to the rich and those in high social status, it should not presume to dictate to the poor. Furthermore, the economic position of this group must be borne in mind.

TABLE VIII

Ages of Wives and Husbands at First Clinic Visit

Age groups	Wife	Husband
Total	1000	1000
16-20	9	2
21-25	179	92
26-30	304	279
31-35	246	244
36-40	192	215
41-45	63	109
46-50	6	40
51-55	1	12
56-60	0	5
61-65	0	2

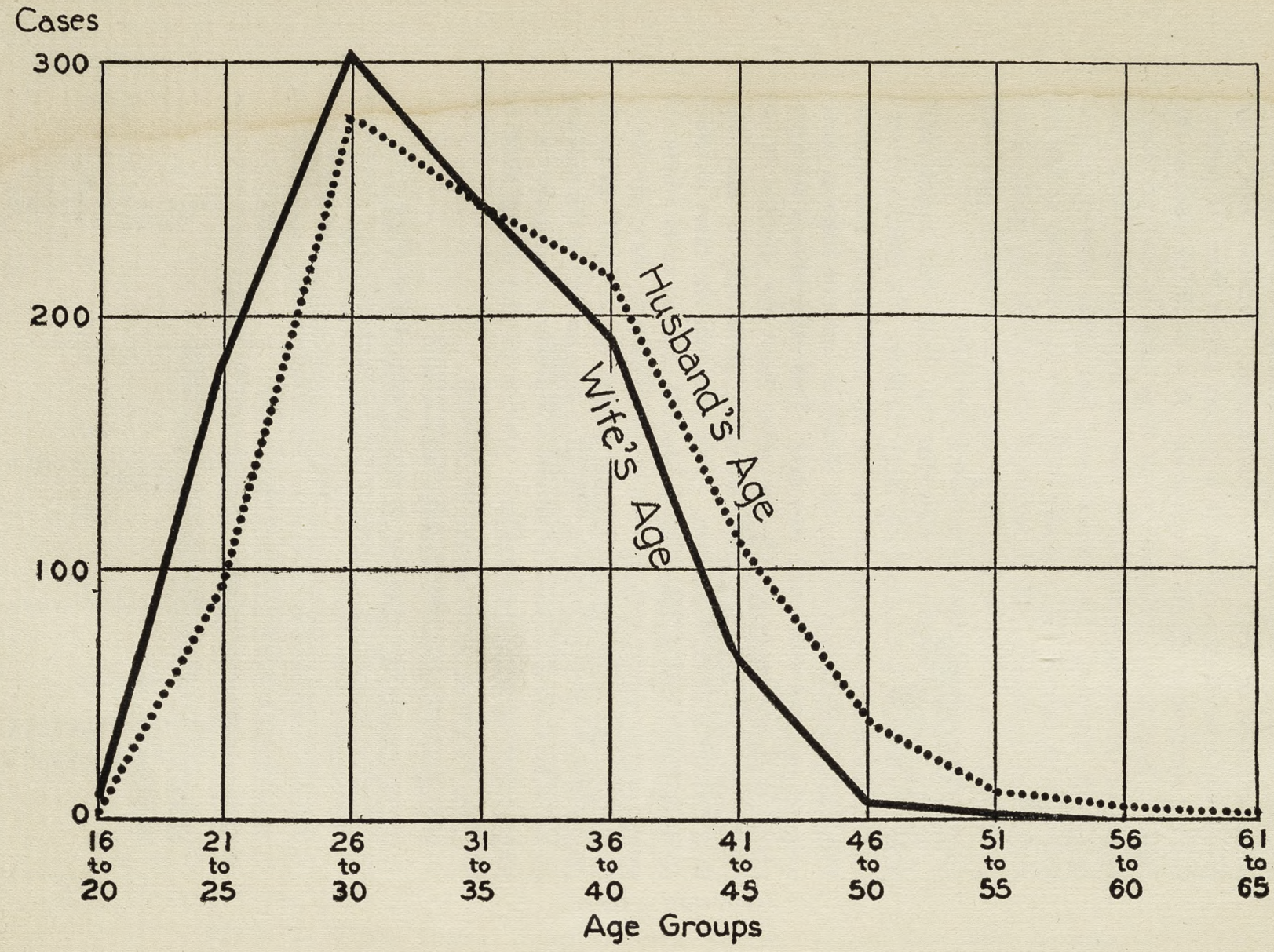

FIGURE E—AGES OF WIVES AND HUSBANDS AT FIRST CLINIC VISITS

There was a high degree of relationship between the number of years the clients were married and the number of pregnancies undergone, the correlation coefficient being .73. The relationship between the number of years in the marital state and the number of living children in the family was lower, the correlation coefficient being .60. The standard deviation of the mean of pregnancies (3.86) was 2.83, the standard deviation of the mean for living children being 2.56; while the standard deviation of the mean for years married (8.77 years) was 6.0. Partial correlations, to correct for the ages of the wives and husbands, have not been made, partly on account of the labor involved but essentially because it was doubtful whether the figures could thus be refined usefully.

Economic Factors. The economic position of the clients needs to be considered in relation to the size of their families and their need for contraceptive information. Table IX, which is a classification of the husbands' occupations, makes no pretense to being accurate. The meager information furnished on the clinic cards is only approximately correct, and, at best is difficult to classify. As defective as this table must be, it gives some picture at least of the occupational and economic status of the clients who call on the clinic for assistance. The term "higher business" simply denotes the more responsible of business positions. It is clear that the clinic served the wives of no industrial magnates. It can be said with assurance that more than half the clients' husbands are skilled, semi-skilled, or semi-responsible workers. Of the definitely unskilled there were 379 cases or 38 per cent. of the total. There is a notable group of motor traffic employees (90), mostly 'bus conductors and drivers, which classification includes a few chauffeurs and mechanics. The fact that husbands of 9 per cent. of the clinic's patients belonged to so definite an occupational group is accounted for by the fact that one of the London 'bus routes terminates directly in front of the clinic. This illustrates the intercommunication of such knowledge in a given economic group, as no doubt word went round that contraceptive information could be obtained at the queer looking little place one worker pointed out to others.

Additional light on the economic status of the group is given by a study of wage incomes. No tabulation has been attempted of the wages recorded on the clinic cards on account of incompleteness of the data. In many cases it is impossible to distinguish between wages received by the husband and the amount turned over to the wife.

There are husbands who do not permit their wives to know how much they earn. The wife receives a certain amount on which to operate the household and that is the extent of her knowledge of her husband's earnings. We doubt whether there are any motives operating tending to induce patients to understate their husband's earnings. Despite the fact that some figures on the clinic records represent weekly wages and others the wife's allowance, it is possible to secure a fairly definite idea of the wage rates and of their range. Not infrequently the amount recorded is one pound fifteen shillings ($8.75). Very seldom does it exceed two pounds ten shillings ($12.50). In fewer than one per cent. of the cases would the amount run from three to five pounds ($15-$25) per week. The highest weekly wage recorded in this series was five pounds ($25). It is a very conservative statement to say that the average family of five in this group—for it will be recalled that there were, on the average, three living children in each family—must support itself on an income that seldom exceeds twelve dollars per week. Since prices are very nearly as high as in this country, this fact must be taken into consideration in judging the need of modern contraception in this group. Then again, not a few patients were the wives of disabled soldiers, unemployed men, or men on the dole. In a very few cases the husband was described as "a mental patient."

The percentage of wives of skilled and unskilled workers has a direct bearing on the important question of the selective influence of the birth control clinics. Fourteen per cent. of the clinic's patients were the wives of labourers. In all, at least 38 per cent. may be considered definitely unskilled. If one were to include the petty tradesmen and assistants, clerks, policemen, soldiers and sailors, 55 per cent. of the total group would be considered the wives of unskilled workers. While the husbands of a few were unemployed, those on the dole, or those receiving unemployment pay constituted a negligible proportion of the total group.

There has been no direct way of guaging the intelligence of the patients except by observing their general conduct, their capacity to learn readily the method taught them, by studying their attitudes and the nature and extent of their coöperation. One of the authors (Mrs. Himes), who volunteered her services to the clinic for several months, and who came into considerable contact with a number of the patients both in the clinic and in the course of the home visits summarized later in this paper, came to the conclusion that few patients were of

TABLE IX

HUSBAND'S OCCUPATION REPORTED BY 1,000 WOMEN SEEKING BIRTH CONTROL ADVICE

Total	1000
Unskilled labor	379
Common	143
Porters	50
Car men	26
Miscellaneous	160
Skilled and semiskilled labor	328
Motor traffic	90
Miscellaneous	238
Petty tradesmen	70
Clerks	57
Police	33
Higher business and professional	17
Soldiers and sailors	14
Unclassified and unknown	102

very low intelligence. With a few exceptions most of them seemed to belong to the more prudent, far-sighted, and intelligent elements of the working classes. It is doubtful whether the clinic has ever advised a feebleminded person. It is, however, hardly within the province of the clinic's work to serve this group. The problem of restricting the continuance of such strains is a task not for voluntary birth control clinics but for the State which is trying half-heartedly to control it by segregation. We say half-heartedly, because there is no officially recognized sterilization in England of those feebleminded individuals who, once detained in training schools, are subsequently released into the community, often to propagate their kind. What one might term the poor-law group also seems to be scarce in the North Kensington series.

The question remains an open one, therefore, whether the clinic is getting contraceptive information to those members of the community who have but little foresight, initiative, intelligence, and germinal capacity.[15] A few leaders of informed opinion are inclined to the belief that the voluntary centers giving this advice will always be limited in this regard and that this constitutes one of the main reasons why such advice should be made available by the government at the two thousand or more infant welfare centers throughout the

United Kingdom. It is surely the height of folly to expect those of limited initiative or meager intelligence to demonstrate in action qualities they do not possess and which they go on spreading in the community because we are unwilling to act promptly in the matter.

Follow-up Study Based on Clinic Records. Of 1,000 cases which constituted the original series studied, 855 were fitted with the appliance usually recommended by the clinic and 145 cases were not so fitted for the following reasons:

Certainly pregnant	30
Probable or suspected pregnancy	57
Referred to hospital	15
Other method wanted	5
Too constipated	3
Too small introitus	2
Too run down	1
"Did not stay"	1
Miscellaneous	4
Reasons not specified	27

English clinic officials often call attention to the fact that birth control clinics assist in the discovery of conditions needing treatment not available at birth control clinics. Probably, however, they refer only the most glaring cases to hospitals and dispensaries.

Of the 15 patients in this series of 1,000 referred to hospitals, five wanted children. The others had the following conditions: "ready bleeding of cervix on touch;" "large cystocele;" "retroversion;" "enlarged uterus, no sign of pregnancy;" "uterus bulky, slight blood-stained muco-purulent discharge, question condition;" "miscarriage one week ago, still losing;" "small tumor on anterior lip;" "cystocele, rectocele, lacerated and eroded cervix;" "second degree prolapsus uteri, tender left ovary, torn cervix, deep scar;" and "question of left salpingitis, tender left ovary."

Of the 13 cases in which follow-up by home visits was possible, one-third (4) had carried out the clinic's recommendations and one-third (4) had not. Another third (4) could not be located and one case had died.

This is a much smaller number of refusals than the experience of American clinics shows, doubtless owing to a selective factor—the British clinics having no restrictions on admissions "for medical reasons only." But perhaps the most striking feature of this summary is the number who came for advice after they were already pregnant. Of those not fitted, 87 patients, or 60 per cent., were definitely pregnant or probably pregnant. This group constituted nearly nine per cent. (or one in eleven) of all the patients seen. In such cases the usual clinic procedure is to refer the patient to an antenatal center and to urge the patient to return after delivery. It would be of interest if we knew what proportion of the patients so referred had the initiative to return to the clinic for contraceptive advice after the baby was born. The authors believe the percentage would probably be small. Judging by conversations we have had with the officials of provincial (i.e., up-country) clinics, we are of the opinion that pregnancy or suspected pregnancy is the chief reason for the non-instruction of patients in other clinics as well. A more definite answer on this point will be forthcoming when the summary of records of the provincial clinics is completed, which study is now proceeding.

There are many reasons why clients come to the clinic after they are already pregnant. Some are doubtful about their condition and come perhaps more with the aim of ascertaining whether or not they really are pregnant than for the purpose of securing birth control advice. Others, confusing birth control with abortion, come with a faint hope that the doctor or nurse will interrupt their pregnancy. This tendency of patients to come for advice after it is too late also suggests a tendency for which there is other corroborative evidence. We refer to the unwillingness of many women to undergo the necessary trouble and inconvenience which modern contraceptive measures necessarily entail upon the individual. It is partly due to a lack of foresight and to indifference; but there are other extenuating circumstances; sometimes poor housing conditions, or the presence of children make the application of methods a little difficult. When all has been said in favor of the patients' coöperative spirit, however, it needs to be added that often clients do not seem to have either the desire or the will to do their share. It is pathetic, for example, to note cases of women who are not fitted at the clinic because they are pregnant, returning home in despair only to try some futile and perhaps expensive home or "chemist shop" (i.e., drug store) remedy. She is delivered of a child several months later, still she has not learned that contraception is preferable to ineffective, self-damaging attempts at abortion; she will not return to the clinic of her own initiative to seek the proper preventive for this ghastly business of

repeated abortions. A few patients seem "too poor to care." A few that call for advice have been so harassed by grinding poverty that any spark of initiative they once had has evaporated into an air of despair or discontent.

The veriest tyro in hospital work knows that it is next to useless for a physician simply to dole out advice if patients will not, or indeed cannot, owing to character difficulties or home circumstances, follow the advice in their homes. It was with the purpose of overcoming difficulties of this nature that Dr. Richard C. Cabot many years ago instituted medical social service. Perhaps the greatest shortcoming in the procedure of all the British birth control clinics is inadequacy in extra-clinical or home follow-up. There is need for the adoption of American methods in this respect. Such a change would not only render the clinics' services much more valuable but would enable them to determine where they were heading.

Returning to the summary on page 606, pregnancy is the main reason why patients are not treated on their first visit. Though occasionally a client loses her courage after she reaches the clinic and will not see the doctor, such cases are rare. Usually the person who has courage enough to step inside the clinic has courage enough to go through with the simple examination necessary.

The North Kensington Women's Welfare Centre has not experienced the trouble with so-called "difficult cases"—meaning difficult to fit—which Dr. Marie Stopes reports in her "First Five Thousand." According to Dr. Stopes' report the percentage of abnormal and difficult cases increased from 1.75 per cent. in 1922, to 13.77 per cent. in 1923, increasing even to 33.80 per cent. in 1924. Whether or not the difference may be the result of the use of a non-cervical cap at North Kensington we are not prepared to say. This may be an important factor, though of course Dr. Stopes would deny that this was a relevant consideration.

Second Visits. The purpose of the second visit is to determine whether or not the client has so learned the technique taught her that she can carry it out herself safely and without danger to her health. The patient is, therefore, advised to return one week after the first visit so that the doctor or nurse may see that the patient inserts the appliance properly and otherwise carries out instructions. This first week is often referred to as the "practice period." At the second visit the douche or syringe as well as the pessary ointment are sold to the patient, these being held back during the "practice" period in order

to induce such a return. It is a convenient way of impressing on the patient her own responsibility.

Of the 855 fitted patients 654, or 77 per cent., returned for the second visit though not always promptly. This relatively good percentage showed that they were for the most part coöperative. At least 513, 79 per cent. of those who returned for the second visit, inserted the instrument correctly after having been taught on the first visit. In 21 cases, 3 per cent., it is not possible to determine, owing to defects in the records, whether or not the patient had learned what she had been taught on the first visit. Nearly one-fifth of the patients had to be retaught.[16]

Of the 120 whom it was necessary to reteach, 36 returned the following week when they were successful; or, if not successful, they repeated their visits until they had learned the technique, one patient returning for four weeks in succession. Forty-four did not return the following week as directed but visited the clinic later. However, 40 lost all contact with the clinic.

Follow-up Visits. The "follow-up visit" to the clinic is supposed to be made by the patient six months after the first visit. The patients are instructed very carefully to visit the clinic once each six months. If they do not call after six months, it is the clinic's aim to send a "six month letter" reminding the patient of the importance of this visit. A similar procedure is followed if the second visit is not made.

For the purpose of the study of these follow-up visits, 813 cases constituted the series, since 187 cases had made their first visit to the clinic within the seven months period immediately preceeding the date on which the data for this summary were collected. Sufficient time had not elapsed, therefore, allowing a month of grace, for the six month visit to be expected. In all, 445 letters were sent, 82 being second visit, and 363 being six month letters. Some patients, therefore, received no letters at all. The failure to be more thorough in sending out follow-up letters results mainly from two causes. First, a lack of funds entails the use of the service of volunteer workers for all save the duties of doctor, nurse, and housekeeper. The secretary is burdened with many duties. Second, there is considerable doubt as to the effectiveness of follow-up by means of the use of letters.

Of the 813 cases mentioned as available for the study of follow-up:

283 reported to the clinic in person or by letter.
189 were visited in their homes; of these 41 had moved or given a wrong address and two had died; reports were, therefore obtained on only 146.
43 were both visited in their homes and had made return clinic visits.

Therefore, in all 386 cases have personal follow-up records, and of these 21 were not fitted. This leaves a series of 365 cases for the study of the effectiveness of the method taught. The reports may be summarized as follows:

1. After six months to two years the methods were being used satisfactorily in 263 cases, 72 per cent.
2. The rest, 102, were not using the methods prescribed, or this was unsatisfactory, for the following reasons:

Uncertainty in technique	34
Lack of confidence	11
Other methods preferred	8
Pessary hurt patient	4
Pessary hurt husband	3
Husband refused to allow patient to use method	5
Lost pessary	3
Menopause	2
Separated from husband	3
House too inconvenient	1
Wore ring	1
"Failures"	8
Conception before pessary used	3
No reason specified, record incomplete	16

II. Home Visits

When it was seen how ineffective letters were in bringing old patients back to the clinic it was decided to visit the patients in their homes. Hundreds of them were never heard from after their first or second visits, and consequently the clinic had no way of ascertaining the value of its work. Several observers who have lately published statistics on the merits of their respective methods have taken it for granted that patients who have not returned or reported to the clinic have been using the method successfully since their first visit. In other words, it has been assumed that "no news is good news." It was partly with the purpose of testing this theory, the tenability of which was doubted, but primarily with the purpose of studying the effectiveness of the clinic's work, that home visits were made by one of us to as many patients as time permitted. The persons thus visited

had all been given instruction with the exception of the small number already considered who had been referred to hospitals. No report had been received from these patients since their first or second visits, which had taken place one or two years previously.

The population of the slums is a shifting one, and, as was expected, many patients had moved or could not be located. Those who were interviewed were friendly and gave whatever information they could. Several people were particularly coöperative, inviting the investigator into their homes and speaking of their experiences at length.

In the interviews an attempt was made to cover the following points: whether the patient was using the appliance or not; if not using it, the reasons; if using it, whether or not it was satisfactory. It was also the investigator's aim to ascertain the patients' psychological reaction to the use of contraceptives but little success was attained. The failure was due to the fact that the limited time at the disposal of the investigator did not permit of establishing the necessary confidence which is an essential prerequisite to securing information of this sort. A social worker employed by the clinic and in constant and friendly touch with the patients served by the clinic would have little difficulty in gaining the information desired. However, the clinic's executive committee were not convinced of the desirability of such a study, and it probably will not be attempted.[17]

Many of the women interviewed were rather inarticulate; if they were not using the appliance or found objection to its use they expressed their reactions by saying that they hated to "mess around," or they "couldn't be bothered," or they were "too nervous." There were, of course, some outstanding exceptions. Several women not only discussed the general theory of contraception but also spoke frankly of their own opinions of the various methods they had tried. The investigation into the psychological attitudes of the patients visited in their homes, while not as satisfactory as the home visitor had hoped, demonstrated the usefulness of the procedure.

The women coming to the clinic for advice on how they can become pregnant are always of special interest, and a particular effort was made to see them during the course of the home visits. But definite reports could be obtained from only two. One woman had gone to the hospital but had been told that nothing could be done for her. Since that time her husband had been taken to an insane hospital and she felt that under the circumstances it would be better for her

not to have any children should her husband return. The other woman, following the clinic's recommendation, had had an operation at the Samaritan Hospital. Shortly after the visitor had called at her home, she returned to the clinic where the doctor diagnosed "early pregnancy."

Analysis of Home Visits. Of the 96 cases visited in their homes 28 could not, upon repeated visits, be located, so that 68 patients were interviewed. Since 10 of these were non-fitted patients referred to hospitals only 58 of the patients interviewed had received treatment. Of this number, 26, 45 per cent., were not using the appliance recommended while 32, 55 per cent., were employing the device, 18, 31 per cent., satisfactorily, and 14, 24 per cent. unsatisfactorily. In this last group all but one woman had become pregnant. The patient who had not become pregnant had, subsequent to her first clinic visit, consulted another physician who recommended a medicated sponge. This had been successful for one and one-half years previous to the investigator's visit. Of the 13 cases who became pregnant the device seems to have failed in 3 cases, to have hurt so that it was probably not regularly employed in another case, to have been used with carelessness or faulty technique in the remaining 9 cases. In the 26 cases not using the method taught the following reasons were given: 6 preferred other methods (the sheath or withdrawal), 9 lacked confidence in the method, 1 desired another pregnancy, 4 were not permitted to use it by their husbands, 1 said the appliance hurt her husband, 2 were separated from their husbands, and in 3 other cases the appliance was either temporarily or permanently not needed because of the husband being in a hospital or because the patient had been sterilized or reached the menopause. Practically all of these 26 cases had never used the method taught.

The North Kensington Clinic does not inquire whether or not the husbands approve of the wives' visits. At Liverpool, however, where this information is gathered, we have found that, in a series of 234 cases, the husbands approved the visits in 66 per cent. of the cases and that in an additional 30 per cent. of the cases there was no definite information with perhaps a presumption in favor of their approval. In only one case was there a record of a husband disapproving of the visit. It may be remarked that a goodly proportion of the Liverpool patients are the wives of common dock laborers.

The fact that nearly half the fitted, interviewed patients were not using the methods taught demonstrates the need of a more adequate

follow-up by trained social workers. In some instances, to be sure, there was no further need for the appliance, but in other cases where the woman lacked confidence in her technique or an ignorant husband refused to allow her to use the device there has been need for a greater effort aiming at the elimination of mal-adjustments and special difficulties. This the clinic might well be able to carry out if funds were available to employ a full time staff social worker who could maintain a *constant* contact with the patients. There are countless difficulties repeatedly arising in the patients' attempts to carry out instructions which could well be investigated by a visiting nurse or social worker and referred to the staff physician. There is, for example, great need for work among the husbands as their ignorance will always be difficult to combat. It might not be altogether infeasible to undertake a special type of educational work in such cases. Perhaps the clinic could arrange regular meetings for husbands to be addressed by the staff physician (tried at Walworth Clinic in London for a while) or, preferably, they should be seen individually. When patients have active tuberculosis, an uncompensated heart condition, Bright's disease or any other serious disorder likely to render pregnancy extra hazardous (see the discussion of medical indications in footnote 14), the clinic has an unusual responsibility to see to it, by means of follow-up, that the patient successfully applies the technique she has been taught. The same duty is clearly present when either parent is likely to give birth to syphilitic, defective, or deformed children.

We hope the home visits have shown (1) that one cannot tenably maintain that the women who have lost contact with the clinic are successfully and satisfactorily employing their newly gained knowledge. No news is not necessarily good news. Often it is bad news, if indeed it may be said to be any "news" at all. (2) Thorough follow-up in the form of home visits, though expensive, is absolutely indispensible to the intelligent service of the clinic. This can best be done by trained, full-time, salaried social workers.

REFERENCES

[1] "An Essay on the Principle of Population . . ." London, 1803. The first edition published in 1798 was essentially a reply to the Perfectionists (Godwin and Condorcet) who held misgovernment responsible for most of the world's misery. In his first edition Malthus showed the influence of the rate of population increase on welfare but had had no constructive plan at that time for keeping the population within reasonable bounds. It was not until 1803 that he proposed "moral restraint."

[2] In the last edition of the "Essay" published during his life-time (1826) Malthus made it clear that he meant by "moral restraint" "a restraint from marriage, from prudential motives, with a conduct strictly moral during the period of restraint." In so far as Malthus entertained the idea of birth control—and he never seems to have examined its merits—he repudiated it. As Professor James A. Field has observed, "Malthus' spirit of reform stopped at the threshold of marriage. He was radical enough in interposing difficulties between the desire to marry and actual marriage; but once persons were married he left them to the undisturbed guidance of the ethical sanctions which religion and custom had provided."

[3] Among these radicals were the well-known political economists, James Mill and John Stuart Mill, quite probably Jeremy Bentham, the jurisprudential reformer, George Grote, and, of course, Francis Place, Richard Carlile, and a small group of less influential individuals.

[4] Carlile published in 1825 a coarse essay entitled "What is Love?" Reprinted with modifications in February, 1826, as "Every Woman's Book: or, What is Love?" it rapidly went through many editions including an abridged one. It achieved international notoriety. Despite the fact that it was written in bad taste—Carlile was an oppressed radical with distorted judgment—it must needs be remembered that Carlile deserves some credit for being so bold as to write the first book in the English language exclusively devoted to a consideration of the medical, social, and economic aspects of birth control.

[5] Space is not available to discuss at length the important place that birth control now occupies in British politics. It may be said, however, that it appeared at one time as if birth control might cause a serious cleavage in the Labor Party. The Women's Conferences have repeatedly demanded the lifting of the "embargo" on information at the two thousand odd local government welfare centres, the Executive group in the Labor Party as often side-tracking the adoption of these resolutions. From many newspaper clippings received monthly I learn that the subject is continually cropping up in Local Government bodies in one form or another. It has been much discussed in the House of Commons, while the House of Lords has voted 57 to 44 "That His Majesty's Government be requested to withdraw all instructions given to, or conditions imposed on welfare committees for the purpose of causing such committees to withhold from married women in their district information when sought by such women as to the best means of limiting their families." [Parliamentary Debates, House of Lords. Wednesday, 28th April, 1926. Vol. 63.—No. 29.] The House of Lords is thus the first legislative body in the world to take any such action.

[6] See "The Declining Birth-Rate. Its Causes and Effects. Being the [First] Report and the Chief Evidence taken by the National Birth-Rate Commission . . ." London: Chapman and Hall. 1916, pp. xiv+1-450. "Problems of Population and Parenthood. Being the Second Report of the Chief Evidence taken by the National Birth-Rate Commission, 1918-1920." London: Chapman and Hall, 1920, pp. clxvi+1-423. "The Ethics of Birth Control. Being the Report of the Special Committee . . ." London: MacMillan. 1925, pp. xvi+1-179. "Medical Aspects of Contraception. Being the Report of the Medical Committee . . ." London: Martin Hopkinson & Co. 1927, pp. xvi+1-182.

[7] Subsequently it moved to a more central location at 108 Whitfield Street, Tottenham Court, London, W. 1.

[8] Marie C. Stopes, The First Five Thousand. The First Report of the First British Birth Control Clinic. London, John Bale, 1925. p. 6.

[9] R. L. Dickinson, M.D. The Birth Control Movement, Committee of Maternal Health, N. Y., 1927, reprinted from the *Medical Journal and Record* for May 18, 1927.

[10] The Third Annual Report of the North Kensington Women's Welfare Centre (1926-1927) has the following to say about the newly formed Investigation Committee (p. 4):

"It is realized that the ideal method of Birth Control has not yet been discovered. There is no method extant that does not require intelligence and care in use, and many are cumbersome as well, and unsuitable for use in overcrowded homes. It is satisfactory, therefore, to learn of the formation of the Birth Control Investigation Committee which has, as one of its functions, the investigation of methods and the endeavour to improve Birth Control technique. It was started last March [i. e., March, 1926], and is an independent and impartial Committee formed, as its name implies, to investigate Birth Control. It is not propagandist, and its objects are to discover, and eventually to publish, facts as to methods, effectiveness of methods, and the after effects of contraception. The personnel of the Committee comprises two groups; scientists and experts in various aspects of the question on the one hand, and lay representatives with practical knowledge on the other. The following are the experts:—

"Professor Sir Humphrey Rolleston, Bart., K.C.B., M.D., F.R.C.P., (Chairman), E. D. Adrian, M.D., F.R.S., C. P. Blacker, M.B., M.R.C.P., C. J. Bond, F.R.C.S., C.M.G., Professor A. M. Carr-Saunders, Frank Cook, F.R.C.S., Mrs. Gladys Cox, Professor Winifred Cullis, D.Sc., Professor Arthur Ellis, M.D., Professor Julian Huxley and Professor F. H. A. Marshall, D.Sc., F.R.S. The lay group consists of Mrs. Lella Florence (Cambridge Women's Welfare Association), Mr. J. F. Huntington (Walworth Women's Welfare Centre) (Treasurer), Mrs. Margaret Lloyd (Workers' Birth Control Group), Mrs. Margaret Spring-Rice (North Kensington Women's Welfare Centre), Mrs. Mary Stocks (Manchester, Salford and District Mothers' Clinic), and the Hon. Mrs Marjorie Farrer (Hon. Secretary). A questionnaire is being drawn up, and is now in use in a trial form at the North Kensington Centre.

Although no mention is made of this fact in the North Kensington report, I believe the initiative in organizing this research committee was taken by officials of the Cambridge Clinic, notably by Mrs. Lella Sargant-Florence.

[11] For example, inquiry is now being made into the previous use of contraceptives; the method used, period of use, effectiveness, reasons for disuse, and whether adopted immediately after marriage. A more concerted attempt is being made to find out the number of abortions. More space is available to report the results of general medical and gynæcological examinations. There are questions dealing with the reasons for asking advice, the method recommended, and the patient's ability to learn. This last should prove of some eugenic interest. It should also ultimately throw light on the effectiveness of the methods recommended. An innovation is the use of a second card for the further visits. Heretofore, return visits have been recorded on the back of the patient's file card. The patient is asked whether the appliance has been used continuously; whether it has been effective, and whether any difficulties or disadvantages were experienced. Inquiry is also made into the question as to whether or not any supplementary methods are being used in addition to that recommended by the clinic's doctor; whether or not the method recommended has been abandoned, and if so, why. Space is available for recording the opinions of the doctor, the investigator, and the patient as to the good or bad effects of birth control. There is a place for making note of any changes in the size or kind of appliance recommended. Considerable room is left for additional notes.

[12] See *Eugenics Review* (London) October, 1928, on the "British Birth Control Clinics. Some Results and Eugenic Aspects of Their Work."

[13] Stopes, *op. cit.*, p. 42.

[14] In the United States most clinics giving contraceptive advice are limited by law to accepting cases with medical conditions or histories which would make pregnancy inadvisable for health reasons. In a few states such advice may, in the absence of special restrictive legislation, be given for social and economic reasons. No authoritative formulation has been made of the principles upon which contraceptive therapy should be based, though attempts have been made to establish these for therapeutic abortion. The Com-

mittee on Maternal Health (2 East 103rd Street, N. Y. C.) is compiling material on this subject from medical literature and also by the study of case records. In New York clinics the decision rests upon the result of individual examinations, both as to the medical need "to cure or prevent disease" and the type of treatment advisable.

From records of some seven hundred cases the medical indications recognized *in practice* fall into two general kinds so far as the mother is concerned: (A) pathological conditions, either of active disease or functional and structural disturbances and weaknesses which might render pregnancy and delivery extra hazards, and (B) non pathological considerations, having to do with optimum conditions for pregnancy and delivery, including the spacing of offspring and the best seasons. In addition there are eugenic considerations having to do with the quality and health of the children. Among specific conditions listed, five groups bulk large: (1) *Gynecological* and *Obstetrical,* including recent delivery or abortion, deformed pelves, and recent plastic operations; histories of repeated dangerous pregnancies, or deliveries with such symptoms as toxemia, pernicious vomiting, convulsions, too frequent, prolonged, or instrumental labors, and cæsarian sections. (2) *Cardiac* disorders especially with decompensation. (3) *Tuberculosis,* laryngeal, pulmonary, or osseous, if active, and sometimes if arrested. (4) *Nephritis and hypertension,* especially where there is a history of toxemia with earlier pregnancies. (5) *Mental and Nervous,* especially insanity, feeblemindedness, and epilepsy, and certain other nervous disorders.

Besides these five great groups occasional entries appear of anemia, toxic goitre, extreme malnutrition, extreme obesity, diabetes, arthritis, syphilis, and gonorrhea.

Women with some of these conditions should be sterilized rather than left to depend upon contraceptive measures. Conditions of a clearly incurable kind, especially those inevitably calling for interruption of pregnancy if it occurs, should be indications for sterilization rather than temporary measures. Some hospitals are developing a policy of sterilization whenever interruption is resorted to for non-accidental or incurable conditions.

Eugenic considerations include history of sufficient degree of insanity or feeblemindedness or epilepsy in the immediate family, especially where defective children have already been born. Here again sterilization of the mother or father is indicated. Tuberculosis in the immediate family and active syphilis or gonorrhea of the father are other eugenic considerations, however, not calling sterilization into the question. Contraception has not been systematically applied to other large groups in the community who for their own sake or that of their possible offspring might be asked not to reproduce, such as carriers of strains of mental disability, hæmophilia, the deaf, especially deaf mutes, a considerable proportion of whose conditions are increasingly recognized as hereditary, the blind or those otherwise hopelessly crippled, who are so handicapped as to be unable to support children, and possibly, those with family histories of cancer.

—Statement from the Committee on Maternal Health.

[15] This subject has been discussed at length in the *Eugenics Review* article mentioned above.

[16] While the fact that a patient had to be retaught does not mean that she was incapable of learning the technique, it is interesting, even though the figures are not exactly comparable, to compare English and American experience on this point. Dr. Hannah Stone of the Clinical Research Department of the American Birth Control League, reports that less than one and one-half per cent. (ten out of 1,457) patients "could not learn the technique of using any of the methods." ["Therapeutic Contraception" p. 4. Reprinted from *The Medical Journal and Record* March 21, 1928.] It is known that 36 of the 120 English patients were eventually successful in learning the technique, but how many of those who failed to return were actually *incapable* of mastering the method we do not know. The difficulty some patients met

with suggests that a higher percentage in London than in New York might be totally incapable of acquiring the necessary skill. On the other hand, Mrs. Himes, who had intimate contact with many patients, has the impression that all or nearly all the patients who returned times enough eventually learned the technique. Certainly all save the feebleminded and morons *should* be able ot learn it.

[17] Since this article has been written the authors have been informed by letter from a clinic official that the clinic has added a salaried social investigator to its staff.