For 2 years prior to my going to the bureau, I administered the medical services for the planned parenthood mobile unit in New York. So my experience with patients in providing personal medical care in the field of contraception to patients, I think, is fairly considerable.

In rendering contraceptive care to a woman, there is no consideration more important than the choice of method. For unless the method is one which is right for her, it is little better than no method at all.

If you were to ask me my golden rule for rendering contraceptive care, I would give you this:

There is no best method of contraception. Suit the method to the woman. In order to do this, I must evaluate her from the standpoint of her medical history, her physical findings, her sexual history and coital practices, her present social situation into which the use of contraception will now need to fit, to some degree her financial situation, her intellectual capacities, her degree of motivation, the strength and the reality of her desire not to become pregnant, the attitudes she holds about her own sexuality and about various methods of contraception as well as the attitudes of her sexual partner with respect to the same things.

My function and responsibility as a physician are manifold. It is to assess all these variables and to help my patient come to grips with them. It is to see that she is knowledgeable about the methods, each sharing equal time with the others, the mechanical with the hormonal. It is also to inform her of what she might expect from each of the methods from the standpoint of effectiveness and of the most common and the more important side effects, to the best of my knowledge. But it is also my responsibility to help her see these possible effects in perspective, to allay irrational fears, certainly not to intensify them or create new ones.

In this way, my patient and I together may arrive at an intelligent choice. She has come asking me for advice. She leaves me confident that I have rendered that for which she has asked to the best of my medical knowledge, experience and judgment, and that I have neither made the decision with regard to method for her nor left the decision entirely up to her.

A method that is theoretically most effective (that is, the hormonal agents) will not prove to be the best method for my patient if she is psychologically not disposed to use it through fear, lack of motivation, or what-have-you. She will not use it or will use it poorly, risking pregnancy either way. Just as important, a mechanical method such as the diaphragm for which my patient is unable or unwilling to assume the responsibility is going to be equally ineffective. In most cases, if contraception is needed at all, it needs to be a method that can be relied upon, given a woman with a particular temperament and given a particular set of circumstances. A nebulous potential risk of low, almost negligible magnitude measures poorly against the immediacy of remaining not pregnant and what to do with a not wanted pregnancy.

This is not to say that all should have the pill, any more than I would feel that all couples wanting to space their children should use the diaphragm. This is to say only that as a physician, I must