34-year-old woman who has four children and desperately does not wish to have further children.

These are two entirely different women and I think the tendency has been for both women to be offered the oral contraceptive because it is "virtually 100 percent effective."

Well, the first woman, the 22-year-old woman, who is interested in spacing, could accomplish this purpose perfectly well with a 96-percent effective method or a 98 percent effective method. She doesn't need a 100 percent effective method, to accomplish this purpose. If you are a 22-year-old woman with one child, and are planning to have a second child, you are asking for a few months relative security, and if one woman in 200 happens to have that second child 3 months sooner, this is not a medical catastrophe.

But if you have a million such women on oral contraceptives, and 30 of them die because they have used this mechanism when we have simple local means of dealing with the problem, I think this is bad judgment and bad public information. For spacing purposes for the middle-class woman, the diaphragm is still an excellent means of achieving this kind of family limitation or spacing. Carefully practiced rhythm can produce this kind of spacing. Foam can do it. Condoms can do it. The intrauterine devices that are available now can give you a 99-percent or better protection.

I think all of these means, because they are local, and because they are not affecting carbohydrate metabolism, because they do not carry any risk of producing changes in the pancreas and liver and almost in every organ of the body tissue because they are strictly local, are methods of known greater safety. Someone commented that the diaphragm was as safe as an umbrella and possibly even safer since you might trip over the umbrella, and I think that that point is well taken.

If you are speaking of terminating a pregnancy career, again we have better long-range methods of dealing with terminating. If a woman wants to consider whether she wants to have any more children, I can see buying a couple of years of think time on a relatively low dose oral contraceptive. But I cannot see her planning to take it for 20 years in order to arrest all possibility of pregnancy for that period of time.

She and her husband can think about sterilization, she can think about being fitted with an intrauterine device. There are numerous alternatives open to her which are of known greater safety. You have to individualize, I think, according to the needs of the woman and this is where the physician comes in. I don't think we should be prescribing on demand.

This practice has developed rather insidiously—showing women a series of things and then saying, "well, which do you choose?" When a woman comes for an operation, I don't show her a series of incisions and say "Which do you prefer?" I try not to give her a bad result, but I think this is why she comes to a doctor. She comes to a doctor for guidance, and I think that we are derelict if we don't consider and supply her with alternatives.

This problem, I think, has been aggravated also, if I may add a remark here, by the tremendous sums of money which have been put into research with the systemic hormonal approach to birth control.