the Department of Obstetrics and Gynecology of the State University of New York, Downstate Medical Center, and I am director of the largest maternity service in the city of New York and also one of the largest contraceptive family planning clinics in the city. This clinic treats 4,000 new patients a year and has on its rolls 22,000 patients. All of them are from ghetto population. I have a very small private practice.

From the middle of November 1965 until December of this year, I served as Chairman of the Advisory Committee on Obstetrics and Gynecology of the Food and Drug Administration. At present, I am Deputy Assistant Secretary for Population Affairs, Designate, of the Department of Health, Education, and Welfare.

Senator Nelson, I will take you at your word and deviate a little bit from my prepared statement from time to time. I would like to cover a bit of the history of development of modern contraceptive practices, and also a bit of the history of governmental, and regulatory and scientific concern over the modern contraceptives.

We have three types of contraception available to the world's population today. I suppose the first type can really be classified as folklore. This includes coitus interruptus—withdrawal—and the belief that prolonged lactation limits family growth. I do not think we need to talk very much about either one of them. Neither method has been popular in the United States.

We then have the traditional methods of contraception. These include the diaphragm, the condom, the foams, and the jellies. They date back many years and were all that were available to us up until 1960.

Roughly in about 1960, the new or modern methods of contraception were introduced and they made about as much difference to contraception as the jet airplane made to methods of travel. They were different in several ways. We have two modern methods, the intrauterine device, which is a mechanical method, and the oral contraceptives, which are hormonal methods. They are different from the traditional methods in that they are not related to coitus. They could be taken at a time far removed from the sexual act. They were different in the magnitude of their effectiveness. They were usable by populations that neither had the privacy nor the motivation to use the traditional methods.

Both, interestingly enough, were introduced about 1960, and both have become fairly popular, although the oral contraceptives use far exceeds that of the intrauterine devices.

Now, governmental concern and scientific concern about these methods began in about 1961 or 1962 when we began to have reports of difficulty with the oral contraceptives in respect to vascular or clotting diseases. By 1963, these reports, which were scattered case reports at first, had become so serious that governments took cognizance of them. The Food and Drug Administration in this country appointed an ad hoc committee under the chairmanship of Irving Wright to look into thromboembolism, and in England the Committee on the Safety of Drugs, headed by Sir Derrick Dunlap, also undertook the same task.

In addition to that, 2 years later, in 1965, the World Health Organization felt that this problem merited consideration. There had also been scientific meetings.