Now, how are we to interpret these data? Are we to conclude that people who want to take pills should move from Philadelphia and New York to other cities?

Is there something mysterious about Philadelphia or New York that makes taking pills there more risky, or as is more likely and much more sensible, is this simply internal evidence that the sampling and the matching was not homogeneous from city-to-city? If this is true, we are again up against the eternal problem with the retrospective study: is the matching good enough that we can believe the conclusion?

I have said this simply to shake a little bit the absolute conviction with which the thrust of these studies has been put forth. I am not saying there is no risk. I am saying that the risk is not as well established or as certain, at least in my mind, as it is in the minds of some others.

Even if we accept the full numerical risk of the British and the American studies, this gets us to the question of is such a risk acceptable? What is an acceptable risk of death from a pill? There is no simple answer to this question.

There are those, of course, who say that noncontracepting women are healthy women and that no risk is acceptable. This is incorrect from the start, since even the World Health Organization's definition of health states "Health is a state of complete physical, mental, and social well being, and not merely the absence of disease."

Moreover, noncontracepting women are very much at risk—at risk of pregnancy, and pregnancy has associated with it a very real death rate. This death rate does not necessarily depend on obstetrical competence at all. It depends on social and economic status, on prenatal care, on nutrition or malnutrition, factors which are usually beyond the control of the obstetrician.

In our underprivileged groups, the death rate from the complications of delivery is five times as high as the 250 per million in our economically privileged groups, and if you go to a country like Ceylon it is not 1,250, it is 6,000–7,000 per million.

Thus, in 1 year in this country, of 1 million noncontracepting women, 800,000 will end up pregnant, and 200 to 1,000 of these women can be expected to die as a result of their pregnancy, depending on their socioeconomic status. Now, how can anyone say that there is no risk without the pill?

There are, of course, other methods of contraception which carry with them no risk of death from the method itself. With the rhythm method there is no method risk, but lots of pregnancies. It is estimated about 230,000 per million women per year. Of these 230,000 women, from 60 to 300, depending on economic status, will die as a result of their pregnancy.

The older mechanical devices (condoms, diaphragms) give better protection, but still 100,000 or more women will get pregnant of 1 million that use these methods for a year. There will be no method deaths, but the deaths due to these pregnancies will amount to between 30 and 300 per year.

Now, let us look at the newer methods. The table for this is on the next page. Of 1 million women using the intrauterine device for a year, about 50,000 can expect to get pregnant. There will only be about 12 to 60 deaths from the pregnancies, but as we have heard today, there are