deaths from the intrauterine device. The number is not known, but the rough estimate is of the same order of magnitude as deaths from oral contraceptive thromboembolic disease in America.

Thus, there may be 12 to 24 deaths per million users from the IUD itself, and these two factors add up to roughly 40 to 80 deaths per million women using the intrauterine device.

Now, we apply the same statistics to the oral contraceptives. We know that they are much more effective: There will be only about 10,000 pregnancies, and only about three to 15 of these will result in obstetrical death; then we have the claimed thromboembolic deaths of about12 to 24 per million, depending on whether you take the Sartwell or the British statistics. At all events, this adds up to 15 to 40 deaths per million women per year using the pill. On this basis, as far as I am concerned, it becomes clear when all the risks are considered, when all the methods are taken into perspective, that taking the pill is the safest thing a woman at risk of becoming pregnant can do in 1970.

These figures show only the bare bones of the problem. They do not take into account the fact that healthy women who become pregnant against their will often resort to criminal abortion. The sickness and death from this awful alternative cannot even be calculated. It has been estimated that one out of five to one out of 10 unwanted pregnancies is terminated by abortion.

On top of this, how can one measure, and how can one throw into the scales the anxiety, frigidity, maritial discord and infidelity that are generated by the fears of unwanted pregnancies and uncertain contraceptives? Perhaps such human values cannot be measured by computers and statistics, but the physician who has to face the patient day by day has to recognize this, has to put the problem into perspective.

I should like to turn to one other point. Given the uncertain information about side effects, given the probable but certainly not unequivocal information regarding thromboembolic deaths, given the serious question of metabolic disorders (which in my opinion at the moment must remain within the realm of scientific inquiry and supervision, and not in the realm of decisionmaking), given these circumstances—how can one give women a proper set of facts so that they can make an intelligent decision as to whether to use the pill or not?

Human beings are generally not impersonal decisionmaking machines. Emotions tend to color thinking, especially when life or safety is at stake. There are innumerable sayings, like, "The doctor who treats himself has a fool for a patient." How coolly and objectively can a lay person, a woman or her husband, weigh information and make a sensible decision, if they know that there is a risk of life or death, no matter how small, in the decision they make?

Aside from all emotion, making a sound decision requires having the necessary information and being able to evaluate this information correctly. It is certain that these hearings have produced one piece of information about which no one can quarrel: that even the experts on this subject disagree as to the interpretation of many of the available data. Literally centuries of experience have paraded before this committee, and there is no consensus. Is it then reasonable to suppose that a discussion between the physician and his patient, no matter how