ing here that the average woman is essentially so highly fertile that she has a baby yearly.

Mr. GORDON. Could you give us the figure?

I would very much like to have it.

Dr. RATNER. Okay, I would be happy to.

To answer the question of risk of pregnancy by simply giving the gross overall maternal mortality rate only deceives, since the maternal mortality rate varies with the characteristics of the women under consideration. Thus, a woman who is white, young, free of serious disease, of low parity, of upper socioeconomic status, undergoing a well-conducted pregnancy has a radically lower maternal risk than a woman who is nonwhite, older, seriously diseased, of high parity, of low socioeconomic status and undergoing a poorly conducted pregnancy. The latter rate is radically higher.

The relevant scientific question to be answered is as follows: What is the potential maternal mortality rate—the lethal risk of pregnancy—of women on the pill were they not using the pill, nor practicing birth control of any kind, and were active sexually. To help you understand how one arrives at a scientifically valid answer to such a question I will assume a resulting pregnancy and will proceed step by step in arriving at the estimate.

1. 28.0 maternal deaths per 1,000,000 live births represent the total maternal death rate for all women in the United States. (The data is from the official Vital Statistics of the United States for 1967.)

(*a*) 19.5 is the rate for white women;

(*b*) 69.5 is the rate for nonwhite women.

Since nonwhites only constitute approximately 10 percent of the population and since a considerably smaller percent of nonwhite women use the pill than white women, we will assume the rate for white women of.

2. 19.5 maternal deaths per 100,000 live births.

According to Ryder and Westhoff (Use of Oral Contraception in the United States, 1965. Science 153: 199–1204, Sept. 9, 1966) the largest category of women (married) using the pill are in the age bracket of 20–24.

These women according to official Vital Statistics for 1967 have,

3. 11.0 maternal deaths per 100,000 live births.

The reproductive risk, however, varies considerably for individual women within this group. See "Assessment of Reproductive Risk in Nonpregnant Women." A guide to establishing priorities for contraceptive care. Gordon W. Perkins, M.D., formerly medical director of Planned Parenthood-World Population and now of the Ford Foundation. Am. J. Obst. & Gynec. 101: 709–717, July 1, 1968. The author points out that "maternal risk increases with . . . increasing maternal age above 30": "with each pregnancy beyond three"; with the "presence of specific disease entities which . . . includes the following: cancer, cardiovascular renal disease, collagen diseases, diabetes, epilepsy, psychoses, repeated toxemias of pregnancy and severe anemia" and with "the poor." Furthermore, maternal mortality is significantly increased by a poorly conducted pregnancy. Since the greatest users of the pill are to be found in the upper classes, since the great majority of them are free from the serious diseases enu-