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Risks of pregnancy and the Pill

An analysis of the argument that the dangers of using oral contraceptives are smaller than those of pregnancy, reveals serious flaws

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One major reason why most doctors who have prescribed birth control pills continue to do so, despite increasing evidence of undesirable side-effects, is that they hold the Pill to be safer than its alternatives. Other methods are believed not only to have side-effects of their own, but also to be more likely to result in a pregnancy. And, in the words of two doctors, authors of a widely circulated book of medical advice: "So much (maybe too much) has been said and written about the dangers of birth control pills. Let us try to offer some assurance. The dangers of the Pill are less than the dangers of pregnancy" (*The People's Handbook of Medical Care*, by Arthur Frank and Stuart Frank, Random House, p 305).

Before exploring how doctors reached this conclusion, and how valid it is, the recent evidence on the dangers of the Pill deserves to be briefly reviewed, as the magnitude of the problems it causes affects the judgement

of the alternatives. A five year follow-up of the women studied in the often cited British project, which documented the relationship between thromboembolism and the Pill, by Mary B. Badaracco and Dr Martin P. Vessey, was completed recently. It showed that women who developed venous thromboembolism while using the Pill have less risk of a recurrence, after stopping pill use, than do women who never used oral contraceptives but who also developed thromboembolism. This finding (*British Medical Journal*, vol 1, 1974, p 213 and 215) adds further support to the data which link the Pill to abnormal blood clotting, and contradicts the assertion that women who developed thromboembolism while on the Pill were predisposed to the condition. The original Pill users, who later discontinued oral contraceptives, had only one-fourth as many repeat thromboembolic events in the years following the hospital admission for which they were included in the

original study, as the group of women who never used the Pill.

Another recent report has linked the Pill to increased risk of developing a benign liver tumour, although it is too rare to allow for conclusive statistics (J. P. O'Sullivan and R. P. Wilding, *British Medical Journal*, vol 3, 1974, p 7). And a third study, of 12 076 women, has found a somewhat higher rate of urinary tract infections than in non-users. The incidences are reported higher, the higher the amount of oestrogen in the pills used (M. Takahashi and D. B. Loveland, *JAMA*, vol 227, p 762). Finally, a report by Bridgett Mason and her colleagues, released somewhat earlier, indicates that the chemicals in oral contraceptives may affect the blood pressure of Pill takers and cause alterations in their metabolic functions (*British Medical Journal*, vol 3, 1973, p 317).

Best method?

Why do so many doctors and other authorities in the field consider the Pill the "best" contraceptive method? A detailed examination of the reasoning provided by two leading demographers, Leslie Aldrich Westoff and Charles F. Westoff, is illuminating:

"Let us suppose that the eight to nine million women currently taking the Pill discontinue. In an average year, after the situation stabilises, what would be the change in mortality risks? Specifically, how would the reduction in risk of thromboembolism from the Pill be offset by the increase in mortality associated with the higher pregnancy rates resulting from the use of other less efficient methods?" (From *Now to Zero*, Little, Brown & Co, p 101).

One will note an assumption in the Westoff's hypothetical situation—that women who will drop the Pill will conceive because, it is implied, they will turn to less reliable contraceptive methods or use none at all. That assumption has yet to be explained. But let's hear the Westoffs out:

"Let us assume that all of the women in our illustration are trying to avoid pregnancy. First we need an estimate of which methods of contraception would be adopted in place of the Pill. Several studies have been done showing the methods couples used before or after the Pill and the methods they might choose if they were forced to abandon the Pill. On the basis of these different studies, a distribution was estimated which showed about 16 per cent of the couples choosing each of the following methods: the IUD, diaphragm, condom, foam, and no method; 8 per cent using the rhythm method; 3 per cent withdrawal; and the remaining 9 per cent using other methods.

"The next step was to calculate the number of pregnancies that would occur to these 8.5 million women using these methods compared to the number that would have occurred if they stayed on the Pill. The failure rates for each method is based on the 1965 National Fertility Study. The calculation revealed that an estimated 2.46 million pregnancies would occur to the 8.5 million women in the course of a year, while using

other methods compared with the 340 000 that would occur while using the Pill. . . .

"The final step was to calculate the number of deaths that would occur as a result of thromboembolic disease incurred from the use of the Pill and the number of deaths that would occur from abortion and its aftermath. The results of such calculation indicate that 324 deaths would occur to the 8.5 million women on the Pill and that 1179 deaths to the same number if they were using other methods of contraception. Thus, the risk of dying would seem to be three and a half times greater without the Pill."

Whether or not one accepts this theory (no one really knows what millions would do if they gave up the Pill), depends almost completely on whether or not one buys the assumptions. The strength of the Westoff's theorising is that it is not arbitrary but does draw on data—data on what some women did when they stopped using the Pill. It is assumed that if millions would stop using it, they would do what the small population that was studied did. Thus, just as 16 per cent of the former users studied employed no other technique, so too would future millions, and so on.

If instead one assumes an active public educational campaign that directs former Pill users to the more reliable techniques—say, diaphragms—the figures against the Pill rapidly change. The same holds for serious efforts to teach women to use the non-Pill methods they do use, more reliably.

Let me briefly illustrate how readily one can come up with a set of rather different figures and conclusions. If we focus on women 35 or older, assume they would stop using the Pill and rely on local contraception, such as the condom or the diaphragm, and have no abortions, one must expect 2.5 deaths per 100 000 women. If these women did back up local contraception with abortions, there would be only 0.4 deaths (Barbara Seaman, *Free and Female*, Coward, McCann & Geoghegan, p 221). This compares with three to four fatalities, if they would rely on the Pill (Gerald Leach, *The Bocrats*, Penguin Books, p 29).

It is not my point that my premises, and hence model, are more valid than those of the Westoffs' or other projection makers. My point is that the flat medical advice—the Pill is safer than pregnancy—provides the persons seeking medical guidance with no hint of the softness of the assumptions it is built on. Above all, it does not inform them that if they are in a sexually less active age or predisposition, and are willing to use contraceptive methods consciously, the Pill is certainly not safer than alternatives which do not intervene in the chemical balance of the body. Let those whose life and health are at stake decide what they prefer—a more reliable technique (the Pill) or a safer one (the diaphragm), and whether they prefer to achieve higher reliability (at the risk of dying from using the Pill), or if the diaphragm fails, to have a child which its parents may well not want (at the risk of death during delivery).