termination carries a lower risk than continuing the pregnancy to term). Others interpret the act more restrictively. It may not be easy for a woman to find another doctor if her own is opposed on moral or religious grounds to some or all abortions; and if she has little money she may be reluctant to consider the private sector.

The ethical guidelines issued by the BMA state that any doctor who is opposed to abortion has a duty to help patients requesting termination in obtaining alternative medical care. What is not clear is the ethical obligation on a doctor who agrees with abortion in some circumstances but not in others where other doctors might differ. Should he (or she) tell the patient that another doctor might be willing to recommend a termination? Or is it ethically acceptable for him simply to tell the woman that she has no grounds for abortion? Abortion is a complex medical and moral issue and many doctors hold strong, genuine, and varying views on it. They are entitled to do so, but are they entitled to impose those views—whatever they may be—on women seeking advice. Twenty years after the Abortion Act should not the profession have reached a consensus? Surely prompt dispassionate counselling is an essential first step in helping a woman to decide what is best in her particular circumstances.

The Royal College of Obstetricians and Gynaecologists' inquiry found that of all abortions at 20-23 weeks 20% of the women had been referred at 12 weeks and 7% by nine weeks (and that takes no account of delays by general practitioners). Women go from one gynaecologist to another until they get the decision they want. A change in the law to give women the "right to choose" before 12 weeks would mean that women would no longer have to plead with unwilling doctors for an early termination; and it would be more effective than Mr Alton's bill in reducing the demand for late abortions. No one is asking doctors to carry out procedures against their own consciences; but surely the NHS should be providing a uniform service in all districts for women seeking termination.

At present where a woman lives is still a crucial factor in determining whether she has easy access to termination of pregnancy within the NHS. Over half of all women in Britain who have abortions have to pay for the operation,[3] and the regions with low rates of provision of termination facilities are said to continue to appoint gynaecologists with a non-permissive approach to requests by women.[5] Some women at least will go to the private sector only after having been refused termination within the NHS—and the process of inquiry and refusal may take several weeks. Wider provision of NHS facilities with easy access to day care termination would almost certainly lower the duration of pregnancies being terminated.

Even those abortions carried out on the grounds of fetal abnormality may be delayed by inefficiency or by obstruction. The Gallup Survey of gynaecologists carried out last month on behalf of the Society for the Protection of Unborn Children was unsatisfactory in that only 40% of the 1843 gynaecologists replied and the answers were conflicting.[6] Nevertheless, it is of interest that 87% of those replying agreed an upper limit of 24 weeks or later for terminations for anencephaly or other lethal disorders and 69% agreed the same limit for Down's syndrome. Some were opposed to abortion at any stage even for these indications, and a substantial minority opposed late abortion for Down's syndrome. So, though technological advances in genetic diagnosis based on chorionic villus biopsy and in ultrasound imaging should help in the earlier diagnosis of fetal abnormalities, again the individual woman may have no idea initially of the attitude of her doctors to termination of pregnancy on the grounds of a fetal defect. Should the doctor's ethical views (sincerely held though they be) override those of the woman and her husband?

The Alton bill will make it more difficult for women to get a termination. Whatever its defects, the 1967 Abortion Act gave gynaecologists freedom to terminate any pregnancy at any stage when that seemed (to two doctors) the best solution for the mother and the fetus. Debate on this issue is not much helped by the tragic anecdotes that may be cited to support one or other viewpoint, but undoubtedly individual tragedies do occur and will continue to do so. If termination of pregnancy is made illegal in some circumstances then the women victims of those circumstances will be back to the conditions that applied before 1967: the well informed with enough money will go abroad for their termination while the poor, the inadequate, and the hesitant will be left to choose between illegal abortion and continuing an unwanted pregnancy to term.

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Should the pill be stopped preoperatively?

The contraceptive pill became generally available in the early 1960s, and by the mid 1970s about 54 million women worldwide were using it. Coupled with this increased use came reports of serious thromboembolic complications. The first case of pulmonary embolism in a young woman on the pill was reported in 1961 by an English practitioner.[1] Many case reports followed and epidemiological studies showed an increased risk of spontaneous deep vein thrombosis and pulmonary embolism in young women taking the contraceptive pill. This led to the widespread belief that the pill may predispose to deep vein thrombosis after operation, and many women are now advised not to take the pill for four to six weeks before an elective operation.[2] Others are given prophylaxis if they are still taking the pill at the time of the operation.[2] Such advice should not be given lightly, however, as stopping the pill may lead to unwanted pregnancies,[3] and drug prophylaxis for deep vein thrombosis inevitably carries morbidity.

In the 1970s two British cohort studies of more than 60 000 women (nearly half of whom were taking the pill) showed a four to sixfold increase in the relative risk of spontaneous venous thrombosis in young women taking the pill.[4,5] Yet the incidence of spontaneous deep vein thrombosis was remarkably low—43 cases in 23 000 women taking the pill (0·19%) compared with eight cases in 23 000 women not taking it (0·035%).[4] Since 1968, when the two studies began, only five

deaths (three in current users and two in past users) from pulmonary embolism have been reported.[6] Furthermore, pills with a lower oestrogen content than those used in these studies (and so less likely to cause deep vein thrombosis) are now widely used.

The epidemiological studies relied almost entirely on cases of venous thrombosis diagnosed clinically, yet the clinical diagnosis of deep vein thrombosis is associated with both false positive and false negative results even when made by experts.[7] A recent study reviewed young women with suspected deep vein thrombosis who were taking the contraceptive pill and found that only 17% of the clinically diagnosed thromboses could be confirmed by Doppler ultrasound scan.[8] Similar problems apply to the clinical and radiological diagnosis of pulmonary embolism.

Vessey *et al* reported in 1986 that the incidence of deep vein thrombosis after operation in young women taking the pill (12/1244, 0·96%) was about twice that of women not taking the pill (22/4359, 0·5%), but this difference was not statistically significant.[9] The incidence of deep vein thrombosis in young women taking the pill in this study is tiny compared with the roughly 25% incidence detected by iodine-125 fibrinogen scans in patients undergoing general surgical operations; it is also less than the 8% incidence seen in those who receive prophylaxis.[10]

After careful search we have found only three studies of young women taking the pill in which ^{125}I fibrinogen scans were used to diagnose deep vein thrombosis after operation. The incidences of thrombosis in patients taking the pill were 4·6% in 41 patients who underwent gynaecological operations for benign disease,[11] nil in 99 patients who underwent various abdominal operations,[12] and 20% in 33 patients who had emergency appendicectomies.[13] Most women taking oral contraceptives are young, slim, and fit, and they mobilise early after operation. They are usually free from malignancy, varicose veins, and other risk factors for deep vein thrombosis.[14] They are thus unlikely to develop deep vein thrombosis after an operation.

On present evidence the risk to young women on the pill of becoming pregnant from stopping the pill or of developing side effects from prophylaxis may be greater than the risk of developing postoperative deep vein thrombosis. We need urgently to define the true incidence of postoperative deep vein thrombosis so that a rational policy can be adopted. Meanwhile, the pill should not be withheld from young women who require abdominal operations, particularly as in our stretched health service operations are often cancelled at the last minute—increasing the risk of unwanted pregnancy. The routine use of prophylaxis for deep vein thrombosis in women on the pill is probably unnecessary, particularly in those who have no other risk factors.

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Management response to childhood accidents

Slowly—too slowly—health professionals are beginning to recognise that they could do much more to prevent accidents and injuries. Accidents cause much mortality and morbidity, mostly in the young. They thus result in a tremendous loss of productive years of life as well as much grief, suffering, and long term disability. The health service's attempts to prevent accidents and injuries must be scientific and so must begin with detailed epidemiological study of accidents—where, when, how many, of what type, the means of injury, and their severity. The importance of the epidemiological analysis of accidents and the multidisciplinary approach to their prevention is the main theme of an excellent short monograph on *The Management Response to Childhood Accidents* by Pamela Constantinides.[1]

The most comprehensive data on accidents are collected not by the health services but by the police (on road accidents) and by the Department of Trade and Industry's home accident surveillance system. Certainly more support is needed from the Department of Health and Social Security for the computerised accident and emergency record system or developments of it, and consideration should also be given to using the World Health Organisation basic data set developed by the European office of the World Health Organisation. But what does this lead to? "Systematically collected local data on childhood accident injuries can be used to develop policies, target resources and personnel allocation, evaluate programmes and provide a focal point for multisectional co-operation."[1]

Health authorities are urged by Ms Constantinides to improve the management and follow up of injured children, but it is in the possibilities of accident prevention that she makes her most important proposals. The Child Accident Prevention Trust has established an active multidisciplinary group nationally, but both Constantinides and the trust emphasise the value of establishing local groups. Naturally many people such as designers, planners, architects, bodies for setting standards, and legislators play a part in designing the environment and protecting our children from its hazards. The private member's bill on the wearing of seat belts by children in the rear seats of cars is an example of an important national development. But local multidisciplinary groups with local authority personnel—environmental health officers, trading standards officers, road safety officers, and many others—together with voluntary agencies