members of parliament also have referred to such costs.

A society that permits eugenic abortions will never be sympathetic to the needs of families caring for their disabled members. In fact the King's Fund conference agreed that some "screening programmes pay for themselves from the resources saved by having fewer disabled people."

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- 1 Harris R, Read AP. New uncertainties in prenatal screening for neural tube defect. *Br Med J* 1981;282:1416-8.
- 2 Anonymous. More support urged in fetal abnormality abortion cases. *Nursing Times* 1987 Dec 9:8.
- 3 Jay B. Cause of blindness in schoolchildren. *Br Med J* 1987;294:1183-4.

SIR,—I support many of the suggestions made by Dr Tony Smith (13 February, p 446) but he did not mention the dilemma faced by doctors who have moral or religious objections to abortion but who recognise the need to provide their patients with effective choices. This might mean supporting a woman in her request for a termination of pregnancy. The present system requires the doctor to be involved by signing the form HSA1. The suggestion that termination should be available on demand for pregnancies up to 12 weeks would remove this dilemma from those doctors who are merely required to sign their agreement to the operation.

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SIR,—I wish to take issue with Dr Tony Smith (13 February, p 446). Postcoital contraception is not contraception: it is abortion.

Until 1967 the medical profession was united in its condemnation of abortion; then, deciding that ethics must be subservient to the law rather than independent of it, it meekly acquiesced. If it is unethical for me to arrange an abortion it is equally unethical for me to ask you to arrange it in my stead. Indeed I am bound to prevent you from arranging it. This is true ethical behaviour. It is quite clear that the British Medical Association is incapable of logical thought on this matter.

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SIR,—Dr Tony Smith's article contains much that is highly tendentious (13 February, p 446). Most disturbing is his assertion about the morning after pill that no doctor should be allowed "the freedom to refuse on grounds of conscience to prescribe it." We believe that human life begins at the fertilisation of an ovum. The use of the morning after pill contravenes the Declaration of Geneva (to which the British Medical Association was a signatory), where doctors are called on to affirm "I will maintain the utmost respect for human life from the time of conception." The deliberate termination of human life is not consistent with showing the utmost respect for that life. The article alludes to the ethical guidelines of the BMA. It shows a frightening totalitarian spirit to state that doctors should not be allowed to follow these guidelines as they relate to the morning after pill. How can Dr Smith square his statement that "No one is asking doctors to carry out procedures against their consciences" with his

refusal to grant conscientious objection to the prescription of the morning after pill?

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** We have received many letters raising the points expressed by Dr McHardy and colleagues and Dr Langridge and Dr Tony Smith replies: "I believe that when there is a conflict of interest between a patient and a doctor the patient should come first unless there are substantial medical arguments in favour of the doctor. Correspondents such as Drs McHardy and Langridge are saying, in effect, to their patients: 'Most doctors might prescribe the postcoital contraceptive you want but I shall not because I hold certain views about the morality of that action.' The point the leader was trying to make was that 20 years after the Abortion Act became law the medical profession really ought to provide a uniform approach to treatment and that in the case of postcoital contraception objections based on moralistic arguments should not override the patient's rights to be given an accepted treatment."—ED, *BMJ*.

Cancer after nuclear weapons tests

SIR,—Dr S C Darby and others (30 January, p 332) summarise the results of a follow up study of United Kingdom servicemen and others participating in nuclear weapons tests carried out in Australia and the Pacific in the 1950s and 1960s. The defined study group was considered to be about 80% complete. The study design included a control group, comprising servicemen who had also served in a "tropical or subtropical area" but who had not participated in nuclear weapons tests.

The standardised mortality ratios (SMR) among the study group for all neoplasms of the reticuloendothelial system (SMR=100, observed deaths=51) was very different from that among the control group (SMR=56, observed deaths=28), and the question then arose whether mortality among the test participants was unusually high for a group of ex-servicemen or whether mortality among the non-participants was unusually low, or both.

To help address this question I have reviewed the findings for servicemen in the four most recent decennial supplements on occupational mortality published by the Registrar General.¹⁻⁴ (Data from these decennial supplements excluding the most recent may also be found in an excellent review by Logan.⁵) These data should help determine which of the two groups under study (test participants or non-participants) produced the more unusual findings for neoplasms of the reticuloendothelial system among a group of ex-servicemen.

The figure displays relative standardised mortality ratios for all cancers, leukaemias, and other reticuloendothelial system neoplasms for (a) results obtained from the National Radiological Protection Board study and (b) data from the decennial supplements. The relative SMR is the ratio of a cause specific SMR to the corresponding all causes SMR. (The relative SMR for all causes is by definition 100.)

Although the confidence intervals of the relative SMRs for neoplasms of the reticuloendothelial system will be fairly wide owing to relatively small numbers, and data from the decennial

Relative standardised mortality ratios from National Radiological Protection Board study and from decennial supplements.

Decennial supplements: 1951, deaths aged 20-64 among social subclass IIIId armed forces (British and foreign), other reticuloendothelial system=lymphosarcoma, reticulosarcoma, and Hodgkin's disease; 1961, deaths aged 15-64 among occupation order XXVI armed forces (British and foreign), other reticuloendothelial system=Hodgkin's disease only; 1971 deaths aged 15-64 among occupation order XXVI armed forces (British and foreign), other reticuloendothelial system=all reticuloendothelial system excluding leukaemia; 1981, deaths aged 20-64 among occupation groups 041 and 058 (officers UK armed forces, and non-commissioned officers and other ranks UK armed forces), other reticuloendothelial system=all reticuloendothelial system excluding leukaemia.

supplements are not strictly comparable (see footnote to figure), the data suggest that compared with findings from the decennial supplements, test participants had unusually high relative SMRs for neoplasms of the reticuloendothelial system and the control group had unusually low values.

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- 1 Registrar General. *Occupational mortality 1951 decennial supplement for England and Wales. Parts I and II.* London: HMSO, 1958.
- 2 Registrar General. *Occupational mortality 1961 decennial supplement for England and Wales.* London: HMSO, 1971.
- 3 Office of Population Censuses and Surveys. *Occupational mortality 1970-72 decennial supplement for England and Wales.* London: HMSO, 1978. (Series DS No 1.)
- 4 Office of Population Censuses and Surveys. *Occupational mortality 1979-80, 1982-83 decennial supplement for Great Britain.* London: HMSO, 1986. (Series DS No 6.)
- 5 Logan WPD. *Cancer mortality by occupation and social class 1851-1971.* London: HMSO, 1982. (Studies on medical and population subjects No 44.)

AUTHORS' REPLY,—We thank Dr Sorahan for pointing out that the Registrar General's occupational mortality data provide support for the conclusions we drew from the study of participants in the United Kingdom atmospheric nuclear weapon tests programme (30 January, p 332). We doubt, however, if much weight should be attached to the Registrar General's data, as they are obtained by relating the occupations recorded on death certificates to occupations recorded at the time of the census. In the relevant publications the Registrar General warns that so far as the armed forces are concerned occupational mortality data are biased by a tendency for informants to give a service occupation for the deceased, even if he has