

ment more acceptable to mothers by shortening their stay. The effects on mothers and babies have been widely studied,¹⁵⁻¹⁸ and as complications were few their popularity has increased. Another approach has been the introduction of general-practitioner units linked with a consultant unit such as that described by Rawlings.¹⁹

At the West Middlesex Hospital we have tried to alter austere impersonal labour wards and inflexible hospital routines.⁴ Two rooms in the maternity wing have been attractively redecorated and mothers in labour are brought into the unit for delivery by the midwife who has attended them throughout the antenatal period. If all is normal they are transferred home with their midwife as soon as six hours afterwards. Should an emergency arise the hospital staff and facilities are immediately available.

One worrying aspect of early transfer schemes is that the consultant paediatrician no longer supervises the neonates critical first week of life. It is not reasonable to expect such specialist skills from the midwife and general practitioner alone. The provision of community-based paediatricians co-operating closely with the hospital paediatric service, general practitioners, and midwives might ensure that the routine neonatal care of babies at home is comparable to that of babies in hospital. If such care can be provided, the West Middlesex scheme and others like it may form the basis for a maternity service which combines the safety of hospital with the personal qualities of home confinement.

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For Debate . . .

Cancer statistics

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The leading article "Statistical review of cancer in England and Wales" that appeared recently in the *BMJ*¹ emphasised the inconsistencies of "official" statistics. Cancer registries fall into three groups—hospital, regional, and national—but all have to solve five types of data problem. These are commented on below.

OPCS and registry data

1. DATA COLLECTION

Collection of data occurs at hospital level, and the amount of information gathered is usually determined by the requirements of the relevant regional registry, which in turn is guided by the requirements of the national registry, the Office of Population Censuses and Surveys (OPCS) for England and Wales. Since 1970 the Office of Population Censuses and Surveys² has not required the record of disease stage for each patient. Thus a factor *known* to affect survival has been lost for future analysis. The arguments that (a) many centres never record stage and (b) few requests for staged information are made are hardly sufficient.

2. DATA STORAGE

The *BMJ* points out that "reporting varies widely from region to region," and this is also true of methods of data storage. Attempts to computerise cancer registries have not been entirely successful; in some cases the original manual system has been retained in parallel with the computer. Often data backlogs have accumulated and several years have been needed to produce an efficient up-to-date system.

3. DATA RETRIEVAL

Data retrieval is linked to data storage, but a computer system is not always superior to a manual system. If a cancer registry is linked to a large off-site computer a low priority may be given to cancer registry work even if it is an RHA computer.

The Office of Population Censuses and Surveys is unable to produce accurate results when the basic data are poor. An incomplete sample of case histories will not necessarily be a *random* sample—perhaps some long-term survivors will have been lost to follow-up. I suggest that the following information is the *minimum* that is required.

- Date of first treatment
- Date of recurrence (if any)
- Date of death
 - Cause of death
 - Necropsy?
- Patient's state (dead or alive) at yearly anniversaries subsequent to the date of the first treatment
- Details of treatment
- Clinical disease stage at diagnosis
- Tumour histology
- Age at diagnosis
- Sex
- Hospital centre at which first treatment was given

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The estimated date of a recurrence is not always recorded by a registry, although it gives an indication of the *quality* of life after treatment as opposed to total survival time. Histology is often not verified, although this varies with region.

4. DATA ANALYSIS

Techniques used to calculate T-year survival rates vary from the direct method to the life table or actuarial method^{3 4} and the prediction model method^{5 6} and may or may not be adjusted for the age and sex distribution of the particular group of cancer patients.⁷ This should always be made clear to enable comparisons to be made.

5. DATA PRESENTATION

Presentation of data is largely a matter of common sense, but the publications by Reichmann⁸ and Mould⁴ may prove helpful.

DHSS SH3 returns

Other figures are produced yearly for the DHSS on hospital return form SH3. These returns are subdivided by medical specialty and include data on "new" patients, attendances, and treatments during the year separated into inpatients and outpatients. Instructions for the completion of the form are ambiguous in many places. Since statistics on cancer treatment work load must in part determine future policy such as purchase of equipment, the consequences of inaccurate returns are serious. The definition of the term "new patient" varies. For the purposes of the SH3 a new patient for the registration year is defined as one who starts a new course of treatment in that year, regardless of whether previous treatment courses have been given. If hospitals do not realise that a single patient may be counted more than once for SH3 forms the radiotherapy work load will be underestimated. The table gives some 1973 SH3 statistics for eight different hospitals, and there seem to be inconsistencies. These are probably in part explained by (a) some of the patients originally seen at outpatient clinics

receiving treatment as inpatients (number of new inpatients treated in 1973: hospital A 756, B 516, C 325, D 156); (b) outpatients seen but not treated not being recorded (hospitals E and F)—these will probably form a minority and include those of advanced age and with advanced disease at initial presentation—and (c) patients referred for radiotherapy by other consultants not having also been included under the radiotherapy section.

Figures derived from parts 2 and 3 of hospital return form SH3 completed by eight hospitals (A-H) for the year 1973 showing apparent inconsistencies in numbers of new outpatients

Hospital	New outpatients		Implications!!!
	Part 2, SH3: consultation statistics, line 18	Part 3, SH3: treatment statistics, line E(c)	
A	3248	1841	1407 new patients seen but not treated
B	1868	1335	533 new patients seen but not treated
C	1271	927	344 new patients seen but not treated
D	944	825	119 new patients seen but not treated
E	1560	1560	All patients seen were treated
F	241	241	All patients seen were treated
G	838	1248	410 patients were treated but not seen
H	796	892	96 patients were treated but not seen

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² Office of Population Censuses and Surveys, *Report of the Advisory Committee on Cancer Registration*, p 10. London, HMSO, 1970.
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⁴ Mould, R F, *Clinical Radiology*, 1976, 27, 33.
⁵ Boag, J W, *Journal of the Royal Statistical Society* (series B), 1949, 11, 15.
⁶ Mould, R F, and Boag, J W, *British Journal of Cancer*, 1975, 32, 529.
⁷ Berkson, J, and Gage, R P, *Proceedings of the Staff Meetings of the Mayo Clinic*, 1950, 25, 270.
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Every emergency department should have one—
an interview room

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The accident and emergency department is at the interface between the hospital and the outside world, and it is the focal point for many acute social catastrophes. Parents may have to be told that their children have been killed on the road, or a wife may learn that her husband has just had a fatal coronary thrombosis. A room should be set aside for such devastating interviews.

Design of the room

In 1971 I was given the opportunity of helping to design a new accident and emergency department for the General Infirmary at

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Leeds. In the first draft of the operational policy I asked that a pleasant quiet room should be designed close to the reception area for personal interviews with patients' relatives. I had already experienced the seemingly callous way in which it was sometimes necessary to inform relatives of a sudden brutal death and then expose their grief to public gaze. The secretary's office, the sister's office, or even the staff sitting room are used in some departments as a haven for distressed relatives, but this can embarrass both the relatives and the staff and disrupt the work of the department. I had come firmly to the opinion that a room specifically designed for this purpose was essential.

Eventually, as the plans for our new department developed, we located the interview room next to the new patients' waiting area and close to the nurses' station. This has proved to be an ideal arrangement. The door opens discreetly off the waiting area and only the nurse can see directly in. The room is carpeted, has soft lighting, and is furnished with easy chairs grouped around a coffee table. Behind the door is a hand basin and mirror and on the table a telephone to enable people to contact other relatives or friends.

In the six months since these new premises came into use we have kept a record of the various purposes for which the interview room has been used. Normally the room is kept locked but the key is in the nurses' station. When relatives leave the room is locked again, the key is returned to its hook, and details of the interview are entered in a