shown elsewhere that old age, poor survival, DHA of residence, and place of death were all positively associated with DCO registration.1 All the studies Guillo
cite have focused on Thames cancer registry as the sampling frame for studies of case notes and all exclude DCO cases from their sample. Our second concern relates to the use of cancer registry data for health services research. National Health Service (NHS) purchasers are now funding registries directly; we consider it essential that the reliability and the valid-
ity of registry data be confirmed before these are used as a basis for needs assessment, service outcomes, and provision. Registry data cannot be used when they are inaccurate or incomplete. In a pre-
vious paper we haveshown that part of the problem lies with the incompleteness of clinical notes,2 and in that paper we chose to focus on quality control within the registry.

Guillo asks how we assessed the reli-
ability of our own data abstraction.
Before beginning work, the two doctors who carried out the abstraction liaised with registry staff to confirm the criteria used when coding date of diagnosis, stage, and treatment. Data were abstracted on each case by the two doctors separately and checked for interobserver bias. Further checks took place at clinical audit meetings with surgeons and patholo-
gists when cases with absent or discordant information was audited. All of this is de-
scribed in a previous work cited in our paper.9

We regret the ambiguity in the abstract which could be taken to mean that the registry had data on treatment for DCO cases. However, the background and methods sections make clear that the regis-
try definition of DCO cases was the one followed in this study. References to dis-
agreements involving DCO cases in the abstract would be better described as dis-
agreements involving DCO cases for which we subsequently retrieved clinical data. DCO cases are important because their exclusion from the sample can bias measurements of treatment and survival. In other papers we have attempted to measure the impact of DCO cases on national survival and the effect of losing them.1,10

In conclusion may we identify what we take to be the strengths of our paper? Our objective was to identify factors in the registration process affecting reliability. We showed error in three areas in which the registry has explicit written policies: the respective follow up of DCO cases, six-month active follow up of cases, and the coding criteria for date of diagnosis. The registry has responded positively to this audit and to our recommendations for improving the internal quality of registry data.

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Preprinted assessment sheet
Goodyear and Lloyd pointed out the advantages of a preprinted assessment sheet,1 but I would like to point out the danger of implementing this method in the hospital setup, specially for junior doctors in training.

Good history taking in medicine has for generations been the main method of educating medical students and junior doctors. Full evaluation of the history of a patient's complaints is crucial to making a correct diagnosis, and helps in planning the management. Every doctor spends the rest of his or her professional life learning the lesson. The doctor's first task is to listen and observe, not only to obtain information about the current problem but also to understand the patient as a whole and to learn about their life situation.2

Symptoms identified by taking a history provide some of the most important items of information used in the process of diagnosing a disease. When patients describe the symptoms for which they are seeking professional attention, they are also reporting the story of an illness as they have lived, and remembered it, and so it can vary. To some extent, symptoms are universal human experience. Virtually every person experiences some discomfort for which he or she cannot provide help.

Talking with a patient has a third function: it helps that person to feel that he or she is understood, and it thereby helps to establish a therapeutic relation. A style of questioning narrowly shaped for the sole purpose of diagnosing a disease ignores much of what patients have experienced and many of their concerns and questions. It therefore often prevents the development of a trusting relation, and diminishes the chances of helping the patient. Talking with a patient about the experience of being ill, on the other hand, can have great value even when nothing can be done about the disease.3

Collecting information with a pre-
printed assessment sheet, or computer may be more accurate, and might be used for research but is not advisable for young doctors in training. It is the duty of the senior experi-
enced doctors to identify deficiencies in history taking by a junior doctor, and help him or her to rectify the deficiencies and thus become good clinicians.

The disadvantage of a preprinted assessment sheet is that you forget to


Medication errors during hospital drug rounds
In their paper Ridge et al set out to find the nature and rate of drugs given in error in one National Health Service (NHS) hospital. It is important to distinguish between the authors' focus, which was errors that occurred at the time of the nurse giving the drug, and prescribing errors that originate with the doctor and already exist on the prescription. Prescrib-
ing errors were not examined by the authors as their survey recorded only those errors that could be classed as devia-
tions from the doctor's medication order as written on the patient's chart.2

Although it is important that hospitals do review the effectiveness of their current drug supply and administration systems (as the authors suggest), it is incorrect to support the seriousness of this argument with reference to the incomplete record of coroner's records which concluded that about a fifth of deaths relating to prescribing and giving drugs were due to errors.3

In this review, a total of 3277 deaths came to inquest (3.8% of all deaths in the years 1986–91) and the review of coro-
ner's cases actually identified 46 relevant deaths (due to adverse drug reactions or errors in prescribing or giving drugs). Of these 46, death was attributed to errors in medication in 10 cases, with an even mix of primary and secondary care cases, but of these 10 most were due to prescribing errors with possibly only one death due to a nurse giving a drug in error (and that involved oxygen).

The overall risk of death due to errors or adverse drug reactions was judged to be very small – about one in 2000 of all deaths during the study period, and of course, unlike in the paper by Ridge et al, there was no baseline for the number of total events that were potentially adverse – that is, the number of cases of medicines prescribed and given during the six year period.

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