

convinced of the need to record as many such findings as are practicable.

It is important to state that the design of the enquiry is intended to create a register of two distinguishable groups of women whose contraceptive practice, fertility and significant morbidity has been carefully recorded, as well as providing narrative data. Additional data may more readily be obtained if desired.

The size of the study (about 60,000 women years will be scrutinized) will permit the detection of relatively small increases in relatively uncommon conditions. Complete elucidation of the relationships of such increases to oral contraceptive practice may then require the mounting of special *ad hoc* studies. However, the posing of hypotheses in relation to specific complications is considered a prime and very valuable function of the study.

In addition to comparisons between cases and controls, the size of the enquiry will permit comparisons of the amount and severity (measured by hospitalization) of morbidity between takers of different preparations or at different dosage levels. Analysis of intragroup and intergroup differences will often be helpful in explaining sources of differences.

One important consideration in respect of which initial decisions have been left open, concerns the desirability of regular recall of controls at intervals corresponding to those at which prescriptions are given to takers. Although there are arguments for such a procedure in terms of the possibility of casually reported morbidity in the taker group when prescriptions are issued, there is an equal possibility that arranged contacts between general practitioners and controls will produce more casually reported morbidity than will prescription visits. At present such control contacts have not been incorporated but consideration of this issue continues and trials may well be instituted to clarify the question.

Not the least important epidemiological consideration is the methodological one represented by the whole concept of such a mass study based on the Royal College of General Practitioners. The opportunity to place the natural history of so large a population under so intensive and prolonged a scrutiny would be effectively unattainable by any other feasible technique of contemporary epidemiology.

## A COMPARISON OF TWO METHODS OF DETERMINING SOCIAL STATUS

CLIFFORD R. KAY, M.D., M.B., Ch.B., M.R.C.G.P.  
Manchester

Recorder, oral contraception study

THE ATTEMPT TO CLASSIFY THE almost infinite variety of Man's social habits must always result in an uneasy compromise. When no single method can be perfect, different criteria tend to be used for different purposes, but the

aim should be to use a system which can be objectively applied and that has been widely accepted.

In studies conducted in and from general practice, the five-category classification of occupation defined by the Registrar-General<sup>1</sup> has been commonly adopted. The classification has become familiar to research-minded general practitioners and many studies of morbidity and mortality have been published using this convention. It was, therefore, decided to retain this classification for the prospective oral contraception study, although the limitations of the small number of categories were recognized.

In the initial pilot trials of the study, as in previous studies sponsored by the Royal College of General Practitioners, the following description of the five social classes was given to each of the participating general practitioners:

- Class I — Professional occupations.
- Class II — Intermediate.
- Class III — Skilled, including mine, transport and clerical workers and armed forces.
- Class IV — Partly skilled, including agricultural workers.
- Class V — Unskilled, including building and dock labourers.

As this study was concerned only with married women or women living as married, instructions were given to classify them according to the occupation of the husband or consort. Each doctor was asked to make his own assessment of his patient's social status, according to these criteria.

With such limited information, the possibility existed of a wide variety of largely subjective interpretations and it was, therefore, decided to compare the results of this method with a system of central coding based on information given by the general practitioner.

### Method

Members of the Oral Contraception Working Party and those doctors who had assisted in the first trial of the oral contraception study were invited to take part, and ten doctors agreed to do so.

Each doctor was provided with 12 forms, printed on one side with the material shown in figure 1.\*

The doctors were asked to complete the front of one of the forms for each of 12 married women who came to consult them. A random method of selection of patients was adopted—for example, by taking the first two eligible women attending each consulting session. The doctor then recorded on the back of the form his own assessment of the social classification of the patient.

Using the information given on the front of the form, the social classification of each patient was obtained by reference to the Registrar-General's Classification of Occupations. These codings were then compared with the doctors' assessments of social status.

\*This format was devised by Dr A. M. Adelstein and Mrs A. Fish of the department of social medicine, University of Manchester.

Patient's name .....
*Description of husband's occupation .....
.....
His employment status:
Self employed:
Employed:
Manager:
Foreman or supervisor:
Other employee:
Apprentice:
.....
.....
Doctor's name and address: .....
.....
*Give description as completely as possible, e.g. engineer—machine minder; professional engineer; engineer—installing central heating.

Figure 1. Format of the proforma

### Results

The accuracy of each doctor's assessments is summarized in table I.

Dr D's classifications had to be excluded from this table because, although he had given details of the husband's occupation on the front of the form, he had apparently coded the wife's occupation on the back.

TABLE I

DOCTOR'S ASSESSMENT OF PATIENTS' SOCIAL CLASS COMPARED WITH CODING ACCORDING TO THE REGISTRAR-GENERAL'S CLASSIFICATION OF OCCUPATIONS

<i>Doctor</i>	<i>Number in sample</i>	<i>Number not agreed</i>
A .. .. .	12	5
B .. .. .	10	6
C .. .. .	12	—
E .. .. .	12	10
F .. .. .	12	10
G .. .. .	12	5
H .. .. .	5	2
I .. .. .	12	5
J .. .. .	12	5
Total .. .. .	99	48

Of the remaining 99 patients, the doctors' coding of social class did not conform with that of the Registrar-General in 48 cases (48.5 per cent).

In only two instances was any difficulty encountered in determining social class by reference to the Index of Occupations:

Dr G's patient No. 4—Boatman, self-employed, small business.

This was allocated to occupation No. 145 (social class II) but occupation No. 118 (social class IV) might be more appropriate if the business was very small (e.g. one or two men).

Dr J's patient No. 11—Price Inspector.

This was allocated to social class II, but if he were a man of foreman status, occupation No. 140 (social class III) would be more accurate.

In table II the social class distribution of the 99 patients, as determined by their doctors, is compared with the coding determined by reference to the Registrar-General's Classification of Occupations.

**TABLE II**  
DISTRIBUTION OF SOCIAL STATUS OF PATIENTS AS DETERMINED BY DOCTORS OR BY CENTRAL CODING

<i>Social class</i>	<i>Coded according to Registrar-General's Classification of Occupations 1966</i>	<i>Coded by nine doctors</i>
	<i>No.</i>	<i>No.</i>
I .. .. .	8	8
II .. .. .	22	14
III .. .. .	37	31
IV .. .. .	22	27
V .. .. .	8	18
Doubtful .. .. .	2	1
Total .. .. .	99	99

This table shows that the doctors made errors of classification in each social group except Class I. This is the group with which they are most familiar since they belong to it. Apart from this, doctors generally tended to classify their patients into a category that was too low. This may also reflect the bias of a view from the top.

**Discussion**

It must be emphasized that this trial was designed to compare two *methods* of assigning social status. The outcome shows a clear superiority for one of these methods but this implies no criticism of the doctors, who were asked to make decisions based on inadequate information.

There is no mystique in coding. A doctor, or one of his ancillary staff, would have obtained the same results as the central coder if each doctor had been provided with the Registrar-General's Classification of Occupations. For some studies, this may well be the method of choice, but for the oral contraception study in which a large number of doctors will be

participating, central coding will offer economy of time and resources.

Central coding gives two additional advantages. Familiarity with the index substantially increases the speed with which coding can be achieved. Of greater importance, however, is the fact that the occupational data can be classified according to more than one social scale if comparisons with studies classified by different methods is desired. Where automatic data processing is employed this may be achieved by simply coding the occupational data and leaving to the computer the task of classifying them.

This trial has also shown that a description of a subject's occupation and employment status is sufficient to permit unambiguous social classification in almost every case.

#### Summary

Ten general practitioners collaborated in a trial to compare their own assessment of the social classification of a randomly selected group of married women patients with the results of central coding of the same patients.

The central coding was based on a description provided by the doctors of the occupation and employment status of the husbands of the patients and was achieved in 97 out of a total of 99 cases without ambiguity by reference to the Registrar-General's Classification of Occupations. The doctor's coding was based on a very limited description of the same social scale, and was inaccurate in half the cases.

#### Acknowledgements

The working party is indebted to Mrs A. Fish, of the Manchester University department of social and preventive medicine for coding and tabulating the data, and to Professor Alwyn Smith, director of the department, for his ready co-operation. Dr A. M. Adelstein is now chief medical statistician at the General Register Office.

The working party wishes to thank those doctors who kindly took part in this study.

#### REFERENCE

General Register Office (1966). *Classification of occupations*. London. Her Majesty's Stationery Office.

## MEDICAL NEWS

### NOTES ON A HEALTH CONGRESS

LINDSEY W. BATTEN, M.B., B.Chir., F.R.C.P., M.R.C.S., L.R.C.P.

Edenbridge

THE ROYAL SOCIETY OF HEALTH is 92 years old. This was its 75th Health Congress and the third running at Eastbourne. There was a strong atmosphere of 'knowing the ropes'. Opening papers are printed, made up into