Summary

An account is given of the rapid development of a cancer records bureau.

In view of the number of cancer records bureaux being opened throughout the country, it is hoped that this communication may be of assistance to those who are in the process of organizing such centres.

An analysis is given of the figures under each site, showing the methods of treatment and the five-year survival rate for the years 1945 to 1951.

A more detailed analysis is given of the cases registered in the year 1951, the latest year in which we can record a five-year follow-up. The best five-year survival rates for 1951 are 82% for early carcinoma of the uterus, 71% for stage I cervix, and 72% for stage I carcinoma of the female breast.

A new feature in the report is an *incidence table for the year 1955*. This shows the incidence of cancer at each site throughout the body and the number of cases per 100,000 of population, and the figures are shown for males and females separately. The table has roused considerable interest.

My thanks are due to the officers of the South-Western Regional Hospital Board for their unfailing help, and to the cancer records officers, without whose assistance this report could not have been compiled.

REFERENCE

Vick, R. M. (1955). *Brit. med. J.*, 1, 660.

A COMPREHENSIVE DOMICILIARY MEALS SERVICE

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Modern trends in medicine and in social work are directed towards securing maintenance in their own home for as many people as possible who require some help in managing their daily life. Most people prefer to live in their own homes and among their own belongings, and are happier there than sharing any communal life. Patients are now discharged from hospital at an earlier stage of convalescence than formerly, and old people are not pressed into institutions and homes to the same extent as in former years. But to ensure this maintenance it is necessary to supply some form of direct service to assist people to retain independence. Much has been written, and much is known, of the Home Nursing Service and the Home Help Service, and their importance is generally realized. Next after these important services must rank that of supplying a satisfactory midday meal for those who need it. Domiciliary meal services, colloquially known as "Meals-on-Wheels," have been started in many parts of the country, but no considered policy is behind their establishment, and the benefits obtained, though considerable, have not proved as great as they might have been.

Persons Requiring Meals Service

It may be useful here to consider what are the basic requirements for a domiciliary meals service, and also for

what persons should such a service be designed. Roughly, there will be two types of persons requiring the service; the one will require a meal to be delivered for a short time, and the other for a long time, if not permanently. The first group will comprise persons who have recently been ill, either in their own home or in hospital, and who need a well-chosen meal to assist them in their convalescence. When that is complete they should be able to resume a normal life and to cope with their own feeding as they did before they were ill. Some few of these may require a special diet for some specific medical condition, but most will need a well-balanced, attractive, and nourishing "normal" meal. These people will need a meal on at least five days a week, but an ideal service should cover seven, although it is often possible for relations or friends to assist at the week-ends; but the extent to which this is generally possible can be determined only by an inquiry into the needs of a cross-section of the population. These meals should be supplied only on the production of a medical certificate, which can be given either by the doctor at the hospital or by the patient's own doctor, and which should state the type of meal required and the approximate time for which it should be delivered.

The second category of persons requiring a meal can be subdivided into two classes. The first will include those who suffer from some disease requiring a special diet—diabetic, gastric, salt-free, reducing, low-residue, high-protein, and the like. These people may be young or old and will require their special meal for many months, if not to the end of their lives. Meals should be available on at least five days a week, and a medical certificate, signed either by the patient's own doctor or by a hospital specialist, will need to be produced. This second category will include old people who by reason of increasing infirmity are no longer able to buy and prepare food for their own consumption. Many of these persons will need their meal on at least five days a week, but some of the less frail may be content with a meal on one, two, or three days a week. They are capable of doing some cooking and food preparation, but find the strain of doing this daily beyond them, and are delighted by the occasional relief: similar people who can afford it may go to a restaurant for their meals once or twice a week.

These meals may be called "normal," for they do not require to be based on a special diet, but they should be properly balanced, and the menus chosen by someone with a knowledge of nutritional principles. Too often old people suffer from malnutrition because they are careless in their choice of food, or unwilling or unable to prepare suitable meals for themselves. The addition of a few suitably chosen meals during the week can make a big difference to their health. From what has been said, therefore, it becomes clear that a domiciliary meals service should provide a carefully prepared meal, chosen by someone with knowledge of nutritional values and experience in planning a well-balanced diet.

It may be as well to mention here that there will also be a number of patients requiring meals who do not need the meal supplied to their home, but who are fit enough to travel a distance for it. For these a small restaurant may with advantage be attached to each kitchen. The persons served here would need to produce a medical certificate similar to that required for those who need a meal delivered to their home. A review of patients served should be carried out periodically and a renewal of medical certificate obtained. Otherwise some people will continue to receive meals when the need for them has passed.

Kitchens

The numbers of kitchens for preparing these meals will be determined by the distance the vans carrying them will need to travel. Meals should be served between 11 a.m. and 1.30 p.m., otherwise the recipient is either too hungry or not hungry enough. In any large built-up area, therefore, such as London, a number of kitchens will be required.

That being so, it will be more practical and economical if the meals of both types, the special and the so-called "normal," are prepared in the same kitchen. In this way duplication of staff can be avoided, and the same experienced cook can prepare both types of meals, which will then be more suitable for the elderly than those supplied by some of the existing services.

Kitchens can to a great degree be autonomous, and the staff of each kitchen can be responsible, under supervision, for the payment of wages, for keeping records of the patients supplied with meals, and for catering under a system of cost control. The staff need not be large, and for an average-sized kitchen which will supply meals for four vans and for a limited number of restaurant patients a cook-supervisor with a deputy, two assistant cooks, one vegetable cook, and a cleaner will be sufficient. The cook-supervisors employed by the Invalid Meals for London have acquired their knowledge of nutritional values by long experience in the work. If a qualification for new cooks is required, one with the standard of the City and Guilds of London Institute Catering Trades Basic Training Course, or their course in preliminary trade cookery, will be sufficient.

The experience of the Invalid Meals for London may here be quoted. From the six kitchens belonging to the association (one kitchen has since been closed and the patients transferred to another) during the year October 1, 1955, to September 31, 1956, a total of 187,578 meals were served. Of these, 162,002 were delivered by 16 vans: these vans were not, on an average, working to capacity; about 40 meals per van a day were delivered instead of a maximum of 48. A further 25,576 meals were served in the restaurants attached to the six kitchens. 1,635 patients benefited from these meals, an average of 114 meals per patient.

Another reason, especially when dealing with meals for old people, why a careful service is needed is that it is essential that the meal be delivered to the home in an appetizing and attractive form. For this reason the vans in which the meals are delivered should be supplied with some device to keep the meals hot during the period of delivery. One single van cannot deliver more than between 40 and 60 meals during this short period of time. These devices will slightly increase the cost of the service, but the difference in the quality of the service when they are used is immense.

An Absurd State

A difficulty in the orderly distribution of meals arises from the rigid lines of demarcation laid down by the National Health Service and National Assistance Acts. Under Section 28 of the former Act, provision of a meal for an invalid or sick person may be undertaken by a local authority under the arrangements they can make for the care and aftercare of the sick. But by Section 31 of the National Assistance Act a local authority can only contribute to the funds of a voluntary body providing meals for old people, and cannot supply such a service itself. A private member's Bill is at present before the House of Commons which, if passed, will enable a local authority to provide a meal service for old people. The whole absurdity of this state of affairs is obvious if an attempt is made to decide when an old person for whom it is agreed a midday meal is necessary is an invalid or a healthy person. The borderline between health and disease is always difficult to define among the elderly, but there must be few old people requiring a regular meal who do not need a carefully chosen well-balanced one.

Many local authorities do subscribe to the funds of voluntary organizations which supply meals to the aged, but both the standard of the service and the quality of the meals vary greatly, and it is still not common to find a service that supplies a meal on as much as a five-days-a-week basis. And, as has already been explained, if a meal is not available on at least five days a week the service is not doing the maximum good of which it is capable. Some

authorities do provide a service on four days a week, but this does not necessarily mean that they are available to the same old people on four days a week. No one wishes to decry the admirable work carried out by the bodies who supply meals at the present time, but conditions in the country vary so much that chaos may almost be said to prevail, and some degree of standardization is necessary.

An Example of Meal Service

An example of how the two types of meal service can be supplied from a single kitchen is to be found in one of the London boroughs. Here the Invalid Meals for London have a kitchen which supplies invalid meals, of all sorts, for sick persons on the production of a medical certificate. During the week ending March 7, 1958, 1,082 of these meals were delivered on five days a week, by means of six vans belonging to the Invalid Meals for London; in addition 10 patients were served in the small restaurant attached to the kitchen. The gross cost of the meal is about 3s. 6d., but the minimum charge to the patients is 1s. 4d., the balance being made up in part by voluntary subscriptions and in part by a grant from the L.C.C. under their care and aftercare service. Any recipient of the meal who cannot afford to find the 1s. 4d. can obtain help from the National Assistance Board to pay this sum. Of the 233 patients served by these vans, 150 received a "normal" diet and 83 a special diet.

An agreement has been entered into with the local Association for the Welfare of Old People that the Invalid Meals for London should prepare meals for an old people's "Meals on Wheels" service. The meals are supplied at a cost of 1s. 10d. a meal, the association providing for transport, delivery, and all staff expenses, which accounts for the difference in cost of the two types of "normal" meal. The association receives a grant from the borough under Section 31 of the National Assistance Act. No medical certificate is required here, merely a notification to the kitchen that so many "normal" meals will be required. The advantage of this practice is that the "normal" meal is provided by an organization with a knowledge of nutritional values, and is therefore suitable for old people. A further 40 persons, receiving 174 meals a week, are served by one other van under this procedure. The total number of vans supplied by this kitchen is therefore seven.

Medico-social Needs

The terms of the National Health Service Act are more flexible than those of the National Assistance Act, and it would be to the advantage of all who need a meal at home if they could be supplied under its aegis. Enough has been said to show that in our opinion medico-social needs form the basis of most of the demands for meals. The care and aftercare of patients and the prevention of disease constitute such wide terms of reference that there should be no difficulty in including all classes of persons requiring a midday meal under these categories. The frail old person can be prevented from becoming a candidate for a hospital bed by the provision of a well-balanced diet, almost to the same extent that a suitable diet can maintain persons suffering from some specific pathological condition in good health in their own homes. The staff of such a kitchen should be able to consult a dietitian when an occasion arises, but for most of the meals supplied the possession by the cooks of a sound knowledge of nutritional values will be sufficient. A meal service could well be a part of the responsibility of the divisional medical officer or area medical officer service even though the actual preparation of the meal might come under the general care of the catering department of a local authority.

If, however, the service were to become a part of the National Health Service might not, in London, for example, each health division have a central kitchen and the whole service be organized from that? In some of the large divisions a second kitchen would probably be necessary.

Although in theory there should be no need to establish a waiting-list for those requiring meals, in practice there might be some delay in supplying a person with a meal. That being so, it seems that those persons on a special diet, those who have recently been discharged from hospital, and those who live alone should be given precedence over those who live with their own families or with friends.

Such a service as has been outlined will need to be available to all classes of the community. Illness and old age are no respecter of persons, and a person of means will be in just as much need of a suitable meal if ill or old as a person subsisting on little more than a retirement pension. It will be necessary, therefore, for the provider of meals to have facilities for assessing the capability of each consumer to contribute to the cost so far as they are able. A service such as has been outlined is not a cheap one, and many people who can afford to pay the full cost of the meal will be quite willing to do so.

Summary

A comprehensive domiciliary meals service is an essential part of the present policy of early discharge from hospital and maintaining invalids, where possible, in their own home. Such a service should be available on at least five days a week.

Meals should be supplied on the recommendation of a hospital or of the patient's own practitioner, and this supply should be subject to periodic review. Those in charge should have a knowledge of nutrition.

The difficulties in the way of providing such a comprehensive service, owing to the operation of the National Health Service and National Assistance Acts, need to be resolved before such a service can be provided: legislation will be necessary to overcome these difficulties.

The working of a London invalid meal service is described.

Such a service should be the responsibility of the National Health Service working through the medical officer of health and the divisional medical officer.

THE CHURCH'S MINISTRY OF HEALING REPORT OF THE ARCHBISHOPS' COMMISSION

The Commission appointed in October, 1953, by the Archbishops of Canterbury and York to consider the theological, medical, psychological, and pastoral aspects of Divine Healing has now reported. The report* comprises seven chapters and four appendices.

The Commission

The chairman of the 28-member Commission was the Bishop of Durham, the Right Rev. Maurice Harland. There were 14 other clerical members and one non-medical scientist. There were 10 medical members: Mr. E. S. Brentnall, F.R.C.S.Ed., Dr. Denis Brinton, Dr. Ronald Cove-Smith, Dr. J. A. Hadfield, Dr. Ronald Henson, Lady Jefferson, D.P.M., Professor Alan Moncrieff, Professor Sir James Paterson Ross, Dr. Joy Patrick, and Dr. David Stafford-Clark. The nursing profession was represented by the matrons of St. James's Hospital, Balham, and St. George's Hospital, London.

The Commission met 17 times. It sent a questionnaire to 75 interested societies and individuals, receiving 60 replies,

**The Church's Ministry of Healing* (pp. 84), obtainable from the Church Information Board, Church House, Westminster, London, S.W.1, price 2s. 6d. (postage 4d.).

†*Divine Healing and Co-operation between Doctors and Clergy*, 1956, obtainable from the Publishing Manager, B.M.A. House, Tavistock Square, London, W.C.1, price 2s. 6d. (postage 2d.).

and heard oral evidence from 12 persons, who included Mr. Harry Edwards and Mr. C. R. Eddison (who described Christian Science practice). The Commission records its indebtedness to the B.M.A. as follows:

"Since no inquiry into the subject of Divine Healing would be complete without reference to its medical aspects, the Commission, at an early stage of its inquiries, invited the co-operation of the British Medical Association and put to that body a number of questions on which it required guidance. This co-operation was most willingly and fully given and the Commission is greatly indebted to the B.M.A. for its help. The British Medical Association was good enough to set up a special Committee to deal with the Commission's inquiry, and a most full and useful report on its findings was presented to the Commission by members of this Committee—Dr. Mary Esslemont, Dr. E. E. Claxton, Dr. E. A. Bennet, Dr. Peter Edwards, Dr. Doris Odium—in December, 1955."

General Approach

The Commission takes as its starting-point the axiom that the Church is charged with a commission to heal the sick, and that among the Church's members are some who are specially entrusted with a ministry to the sick, notably clergy and doctors and nurses. Their approaches differ, but face to face with a patient the doctor and priest are dealing not the one simply with a sick body and the other simply with a sick soul, but with a person. It is in this unity, states the Commission, that there lies the basis for the kind of co-operation between the clergy and the medical profession discussed in its report. It is trite but important to recognize that there are no such things as disease entities, continues the Commission, but only diseased persons. Healing is a term which can only be used relatively: there is no universally acknowledged absolute standard of physical fitness, of mental or spiritual functioning, which can be used as a measurement. The Commission then notes the ambiguities and difficulties of the terms "faith healing," "spiritual healing," and "divine healing," and states its preference for speaking of the Church's ministry of healing.

The second chapter analyses the *New Testament* accounts of Christ's actions, purpose, methods, and general approach to sickness, and recalls that one of the injunctions he gave to his disciples was to heal the sick and cast out unclean spirits.

Evidence on Healing

Did the Commission receive any convincing evidence that the Church's non-medical ministry to the sick is effective in bringing about physical healing? The Commission does not deny for a moment the possibility of extraordinary and medically inexplicable healings which present themselves to faith as miraculous. But, it says, "the main strength of the testimony to the healing action of Christ in his Body resides, not in occasional marvels, but in the numerous cases where, though nothing medically surprising is noted, faith sees God acting through the ministry of grace as well as through medical means."

The Commission examines the various kinds of evidence needed to support the different claims that may be made about a cure—that healing has really occurred; that it was due to non-medical intervention; that in the light of present medical knowledge the change for the better is beyond any reasonable expectation; that the cause of the improvement was supernatural. With regard to the last claim the Commission says:

"The truth of this cannot be tested by methods of experimental science; for the supernatural is a metaphysical or theological concept which can have no place within any system constructed by science. Nor does the fact that an event is scientifically inexplicable constitute evidence of a supernatural cause. Confronted with what is at present inexplicable the scientist cannot resort to supernatural explanations without transgressing the limits of scientific thinking. It is scientifically meaningless to inquire whether a healing is caused by the grace of God."

Scientific testing can be a valuable corrective of rash claims that healing, ordinary or extraordinary, has occurred,