The usual scene after a death is a ward full of sombre and subdued expressions. Few people talk. The nurses, often very junior, are trying to cope with their own response to death and are not trained in talking to patients. As Fiona Cathcart points out, they receive little training in dealing with death and dying but they also receive little support when trying to cope with these situations.

Although it would help the process of grieving for relatives and patients on the ward to be given the opportunity to see and say goodbye to the deceased, improvements must be made in the support network to accompany this. If nurses are to offer help and counselling they need to be well prepared and they need not just adequate training but support from their fellow professionals.

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Performance indicators for family planning services

We hope that the rates described by Professor Michael Clarke (1 October, p 832) would not be the only performance indicators used to assess family planning services since contraception is only part of the function of a family planning service.

An informal survey in some health districts in Wessex region last year showed that a large proportion (about 70%) of the work of family planning clinics is concerned with the whole subject of reproductive medicine and covers such topics as counselling on psychosexual problems, vaginal discharge, health screening, and giving information on general health, rather than just fertility control. These activities are more difficult to evaluate in terms of simple numbers, or even as outcomes, but listening to these patients, and treating them, contributes to their general health and may prevent future, often expensive, problems for the NHS. Training is another important function carried out almost exclusively in community clinics.

Studies show that patients need both clinics and general practitioners for different times in their lives and these services need to be evaluated separately.

If such performance indicators are used to indicate areas where service provision needs to be increased then they may be valid. The danger lies in using simple figures to monitor a complex subject, fraught with the difficulties of evaluating human emotions and needs, where lower fertility rates may tempt district health authorities to reduce their share of a service just for economic reasons, whereas they indicate that a good service is operating.

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Monitoring during sedation and endoscopy

Like Dr N J Russell (15 October, p 978), we have also monitored cardiorespiratory changes occurring in 20 patients who underwent prolonged endoscopic procedures to identify the periods of risk and evaluate suitable monitoring.

Data were recorded continuously from a lead II electrocardiograph, Ohmeda Biox 3700 pulse oximeter, and a Datascope non-invasive blood pressure monitor by an Atari 1040 ST microcomputer. Sedation was provided with pethidine 25 to 50 mg and midazolam titrated to effect. The study started immediately before the administration of sedative and continued during the examination and for the first hour of recovery.

Firstly, oxygen saturation fell in all patients during the examination (to a mean minimum of 82 (SEM 12·5)%; this decrease remained for the duration of the examination and persisted into the recovery period. At the end of the study 11 patients had not returned to baseline saturation. Secondly, 16 of the 20 patients developed tachycardia during the examination. Ten developed supraventricular or ventricular extrasystoles, or both. Electrocardiographic changes resolved during the recovery period. Thirdly, we found a significant correlation between S-T segment depression and hypoxia ($r=0·941$, $p<0·00005$). No correlation was found between S-T segment depression and blood pressure, heart rate, or rate pressure product.

Cardiorespiratory monitoring is desirable during upper gastrointestinal endoscopy, especially if narcotic analgesics are administered, hypoxia already exists, or the patient belongs to a high risk group. Pulse oximetry provides continuous information on the patient's oxygenation and would appear to be an ideal monitor in a darkened environment. Monitoring should continue in the early recovery period until the baseline saturations are achieved.

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Notification of mumps

Mumps has recently become a notifiable disease in England and Wales to help monitor the effect of the measles, mumps, and rubella (MMR) vaccine.[1] Somerset was a pilot district for implementing the triple vaccine and mumps has been notifiable locally since September 1987. This experience may be of interest to others.

The table shows the monthly notifications of mumps and the corresponding rates per 100 000 population. It was tempting initially to ascribe the rise in monthly totals of notifications to the recent introduction of mumps notification, but in retrospect the rise was probably due to an outbreak of mumps in the area. This is supported by the lack of an increase in the monthly notifications of rubella (which was made a locally notifiable disease at the same time as mumps) and also by the comparison of rates in Somerset with those obtained from the returns to the Birmingham research unit of the Royal College of General Practitioners. These rates are comparatively constant (table) compared with the rise and subsequent fall in the rate over the year in Somerset. The Somerset rate varies from 1·4 to 8·4 times the Birmingham research unit rate.

Notifications of infectious diseases notoriously underreport true incidence; whether this is true of mumps is not known. The accuracy of the notifications is also unknown. On the basis of the notification rates, however, each general practitioner in the United Kingdom may expect to make one or two notifications of mumps in a non-epidemic year and five notifications during a year when there is an outbreak.

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1 Acheson D. *Public health (infectious disease) regulations 1988.* London: Department of Health, 1988. (PL/CMO(88)21.)

Notifications of mumps from September 1987 to September 1988

	1987				1988								
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept
Monthly notifications in Somerset	30	31	57	112	127	134	132	124	85	79	84	98	28
Rate per 100 000 population in Somerset	6·6	6·9	12·6	24·8	28·1	29·6	29·2	27·4	18·8	17·5	18·6	21·7	6·2
Rate per 100 000 population from Birmingham research unit	4·6	3·4	9·2	6·8	11·2	4·1	5·7	6·2	2·6	2·8	2·2	8·4	NA

NA=Not available.

How to communicate with cancer patients

How sad that after an excellent first article on this subject (8 October, p 907) Dr Peter Maguire and Ms Ann Faulkner have allowed themselves to address the problem from the wrong angle in their second paper (15 October, p 972). The clear assumption in the second article is that the patient's spouse has been told the diagnosis but that the patient has not; indeed there is an exhortation to "reinforce that you have no intention of telling him [the patient] and enter into a contract to this effect."

Surely the doctor's "contract" is with the patient, not the relative (assuming the patient's ability to give informed consent), and there is an obligation to give the diagnosis, or as much of the detail as seems appropriate, to the patient first and to seek his or her permission to inform the relatives only after this has been done.

Those of us in the front line of cancer treatment are aware that the increasing desire and ability of patients to receive accurate information about their diagnosis and prognosis put an ethical as well as legal obligation on the doctor to give the patient the facts first. The patient then has the option of informing his relatives rather than the other way round. I have found in applying this principle that the patient is often able to cope with the problems of informing his or her family, that difficulties created by collusion are less often encountered, and that the patient frequently expresses gratitude for the frankness of the doctor.

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Through a glass darkly

Dr Richard Smith's review of *Heavy Drinking: the Myth of Alcoholism as a Disease* by H Fingarette (22 October, p 1055), while accurately describing the development of Jellinek's ideas on alcoholism as a disease, omits the concept of the alcohol dependence syndrome, which is accepted by most doctors working in the discipline in the United Kingdom and elsewhere.

The alcohol dependence syndrome indicates that, like drugs such as heroin and barbiturates, alcohol can induce a state of dependence which