

Web-based Enrollment and other types of Selection: Consequences for Generalizability

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I. Standardization vs. modelling for confounder control in observational studies: a historical perspective

Joint work with David Clayton

Keiding, N. & Clayton, D. (2014). Standardization and control for confounding in observational studies: a historical perspective. *Statist. Sci.* **29**, 529-558.

Selected topics from the dialogue between

Weighting and standardization

Models, parameters, stratification

Marginal effect measures

Conditional effect measures

Simpson (1951): Conditional or marginal effect measures

E.H. Simpson (1951). The interpretation of interaction in contingency tables. *J. Roy. Statist. Soc. B* **13**, 238-241.

M.A. Hernán, D. Clayton, N. Keiding (2011). The Simpson's paradox unraveled. *Int. J. Epid.* **40**, 780-785.

	B=1	B=0
A=1	20	20
A=0	6	6

OR = 1

C = 1

C = 0

	B=1	B=0
A=1	5	8
A=0	3	4

OR = 5/6

	B=1	B=0
A=1	15	12
A=0	3	2

OR = 5/6

Simpson: baby playing cards

C = 1

	B=1	B=0
A=1	20	20
A=0	6	6

OR = 1

	B=1	B=0
A=1	5	8
A=0	3	4

OR = 5/6

C = 0

	B=1	B=0
A=1	15	12
A=0	3	2

OR = 5/6

A = 0 court cards (B, D, K)

A = 1 not court cards (A, 2, 3, ..., 10)

B = 0

B = 1

red (heart, diamond)

black (spade, club)

C = 1 card dirty because baby played with it

C = 0 card clean

Is colour independent of court status?

Yes, marginally OR = 1

No, conditionally on dirtiness OR = 5/6 for C = 1 and for C = 0.

Relevant effect measure: Marginal

Simpson: medical treatment

	B=1	B=0
A=1	20	20
A=0	6	6

OR = 1

C = 1

	B=1	B=0
A=1	5	8
A=0	3	4

OR = 5/6

C = 0

	B=1	B=0
A=1	15	12
A=0	3	2

OR = 5/6

A = 0 not treated

A = 1 treated

B = 0 not dead

B = 1 dead

C = 1 male

C = 0 female

Does treatment affect death?

No, marginally

Yes for males,

Yes for females,

OR = 1

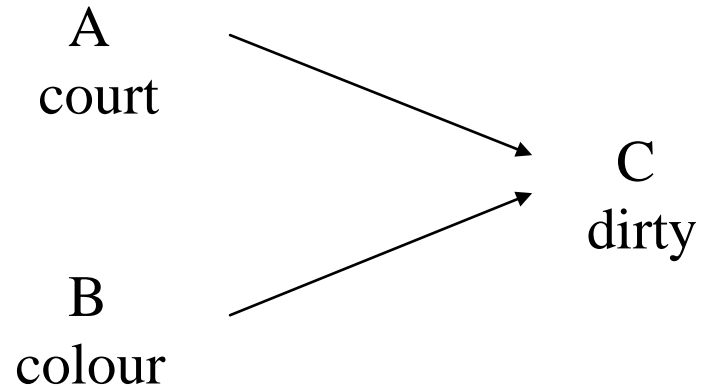
OR of dying = 5/6

OR of dying = 5/6

Relevant effect measure: Conditional on sex.

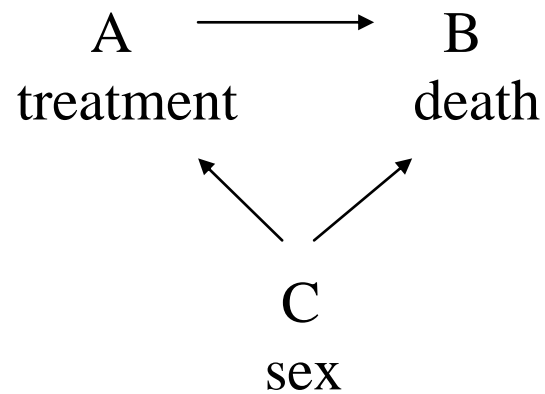
Females die more, females are treated more

Baby playing cards



Even if A and B are independent, they become artificially associated by conditioning on the collider C

Medical treatment



Treatment as well as death depends on sex which is a possible confounder that should be controlled for.

Conditional and marginal effect measures

Marginal: apply age specific rates to a *target* age structure and compare the predicted *marginal* summaries in this target population

corresponds to handling confounders by making sure their distribution is the same in study and control population

Direct standardization, randomized trials

Conditional: compare covariate-specific rates

corresponds to handling confounders by stratification or restriction

Indirect standardization, regression analysis

Direct and Indirect Standardization

	<i>Study population</i>	<i>Standard population</i>	
no. individuals	A_1, \dots, A_k	S_1, \dots, S_k	
age distribution	$a_i = A_i / \sum A_i$	$s_i = S_i / \sum S_i$	
death rates	a_1, \dots, a_k	$\sum a_i = 1$	
Actual no. deaths	$\alpha_1, \dots, \alpha_k$	$\lambda_1, \dots, \lambda_k$	
	$\sum A_i \alpha_i$	$\sum S_i \lambda_i$	
Exp. no. deaths under standard death rates (<i>Indirect standardization</i>)	$\sum A_i \lambda_i$		$SMR = \frac{OBS/EXP}{\sum A_i \alpha_i / \sum A_i \lambda_i}$
Crude death rate	$\sum A_i \alpha_i / \sum A_i$	$\sum S_i \lambda_i / \sum S_i$	
Standardized death rate under standard age distribution (<i>Direct standardization</i>)	$\sum s_i \alpha_i = \sum S_i \alpha_i / \sum S_i$		$CMF = SRR = \frac{EXP/OBS}{\sum S_i \alpha_i / \sum S_i \lambda_i}$

Indirectly Standardized death rate

$$\sum \left(\frac{A_i \alpha_i}{\sum A_i \lambda_i} \frac{\sum S_i \lambda_i}{\sum S_i} \right) = SMR \cdot \text{Crude death rate for Standard population}$$

Direct and Indirect Standardization in terms of target population

T. Sato & Y. Matsuyama (2003). Marginal structural models as a tool for standardization.
Epidemiology **14**, 680-686.

Study (exposed) Population Target:

$$SMR = \sum A_i \alpha_i / \sum A_i \lambda_i$$

compare observed no. deaths to counterfactual no. of deaths if unexposed

Standard (unexposed) Population Target:

$$CMF = SRR = \sum S_i \alpha_i / \sum S_i \lambda_i$$

compare counterfactual no. deaths if exposed to observed no. deaths.

Third possibility: *Total Population Target:*

$$SRR_T = \frac{\sum (A_i + S_i) \alpha_i}{\sum (A_i + S_i) \lambda_i} = \frac{\sum A_i \alpha_i / (A_i / (A_i + S_i))}{\sum S_i \lambda_i / (S_i / (A_i + S_i))}$$

Total Population Target: Interpretation

$$SRR_T = \frac{\sum (A_i + S_i) \alpha_i}{\sum (A_i + S_i) \lambda_i} = \frac{\sum A_i \alpha_i / (A_i / (A_i + S_i))}{\sum S_i \lambda_i / (S_i / (A_i + S_i))}$$

$$= \frac{\sum (\text{deaths in Study Population in age group } i) / (A_i / (A_i + S_i))}{\sum (\text{deaths in Standard Population in age group } i) / (S_i / (A_i + S_i))}$$

numerator: for each age group i , deaths in study population weighted with inverse probability of being in study population

denominator: for each age group i , deaths in standard population weighted with inverse probability of being in standard population

Comparison of several study populations

G.U. Yule (1934). On some points relating to vital statistics, more especially statistics of occupational mortality (with discussion). *J.Roy. Statist. Soc.* **97**, 1-84.

Study populations	A, a, α	B, b, β
Standard population	S, s, λ	

$$\frac{\text{SMR}(A)}{\text{SMR}(B)} = \frac{\sum A_i \alpha_i / \sum A_i \lambda_i}{\sum B_i \beta_i / \sum B_i \lambda_i} = ?$$

no interpretation for
indirect standardization

$$\frac{\text{CMF}(A)}{\text{CMF}(B)} = \frac{\sum S_i \alpha_i / \sum S_i \lambda_i}{\sum S_i \beta_i / \sum S_i \lambda_i} = \frac{\sum S_i \alpha_i}{\sum S_i \beta_i}$$

Direct standardization yields interpretation as ratio of averages, using standard population as weights.

Indirect and direct standardization are not just the same

Historical origin ...

Anonymous [W. Dale] (1777). A Supplement to Calculations of the Value of Annuities, Published for the Use of Societies Instituted for Benefit of Age Containing Various Illustration of the Doctrine of Annuities, and Compleat Tables of the Value of 1£. Immediate Annuity. (Being the Only Ones Extant by Half-Yearly Interest and Payments). Together with Investigations of the State of the Laudable Society of Annuitants; Showing What Annuity Each Member Hath Purchased, and Real Mortality Therein, from its Institution Compared with Dr. Halley's Table. Also Several publications, Letters, and Anecdotes Relative to that Society. And Explanatory of Proceedings to the Present year. London: Ridley.

See N. Keiding (1987). The method of expected number of deaths, 1786-1886-1986.
Int. Statist. Rev. **55**, 1-20.

The STATE of MORTALITY in the LAUDABLE SOCIETY of ANNUITANTS for Benefit of AGE, Bottom of BARTHOLOMEW-LANE, compared with Dr. HALLEY's TABLE, annually from CHRISTMAS 1766 to CHRISTMAS 1775.

Main table with columns for years 1767-1775, including sub-columns for 'Admitted on or since Christmas', 'Number of Deaths and Exclusions', and 'No. Deaths expected'. It also includes a 'Totals at Christmas' section at the bottom.

DEATHS at CHRISTMAS.

Table showing 'DEATHS at CHRISTMAS' for years 1774 and 1775, with columns for 'Real' and 'Expected' values.

Living Members 1332
Deaths and Exclusions 137
State of the SOCIETY at Christmas 1774. Five Papists, and Three unentered 8
Final Number in the Society's Book 1477

Males Piers.	No. of Deaths in SEVEN Years		
	Expected	Real	
.145	2.3084	4	1771 <hr/> .190 .036 <hr/> .034 .013 .012 .018 <hr/> .009 .028 .009 .038 .039 .039 .040 <hr/> .511 .050 .131
.0666	10.9904	11	
.0476	39.0923	23	
.0368	62.2487	33	
.03005	40.7085	17	
.0253	7.5337	5	
.0173	162.5821	93	
.0147			Totals <hr/> Deaths under 21 Years of Age — D°. from 21 to 30 inclusive — D°. from 31 to 40 inclusive — D°. from 41 to 50 inclusive — D°. from 51 to 60 inclusive — D°. upwards of 60 Years of Age —
.01343			
.01210			
.01072			
.00928			
.00937			
.00946			
.00955			
.00964			
.00974			
.00983			
.00993			
.01003			
.01013			
.01104			
1768.	1769.	1770.	
.0202		.0505	
.0268	.0477	.0238	

Direct standardization

F.G.P. Neison (1844). On a method recently proposed for conducting inquiries into the comparative sanitary condition of various districts, with illustrations, derived from numerous places in Great Britain at the period of the last census. *J. Statist. Soc. (Lond.)* **7**, 40-68.

On a Method recently proposed for conducting Inquiries into the Comparative Sanatory Condition of various Districts, with Illustrations, derived from numerous places in Great Britain at the period of the last Census. By F. G. P. NEISON, F.L.S., &c.

[Read before the Statistical Society of London, January 15th, 1844.]

THE present contribution has been made in consequence of the discussion which followed the reading of Mr. Chadwick's paper, at the last meeting of this Society. A new method of measuring the comparative value of life in various districts, was proposed in that communication, in the following terms: "If the ages of any class, or of the general population, living in any district, and the ages of those who die were reduced to the simplest proportions; that is, if the total years of age whether of the living or dying, were divided by the total number of individuals from which the returns were made, the public would be enabled to make comparisons between district and district, and to judge of the relative degrees of pressure in each, of the causes of mortality." It is also stated "That the average ages of death are found to maintain a comparatively steady course, always nearest to the actual condition of the population, and give the most sure indications." And that "the chief test of the pressure of the causes of mortality is the duration of life in years; and whatever age may be taken as the standard of the natural age or the average age of the individual in any community may be taken to correct the returns of the proportions of death in that same community."*

It appears to me that there will be little difficulty in showing that the method proposed is fallacious in principle, and that its practical application to vital statistics will produce contradictory results; and that consequently it cannot be used as a test of the sanatory condition of a community.

J. Statist. Soc. 7, 40-68, 1844.

On this series of tables is founded another table, which I would beg also to submit to consideration. It exhibits the average age at death in the preceding 12 principal towns and counties, also what would have been the average age at death if placed under the same population as the metropolis.

Effects of the irregularities of distribution of Population according to Ages in the under-mentioned Districts, arranged to show the fallacy of proposing the average Age at Death of the whole Population, as a Test of the Sanatory Condition of a Locality.

District.	Average Age at Death.*		Number out of which one will die.		Mortality per Cent.	
	Actual.	Transferred.	Actual.	Transferred.	Actual.	Transferred.
Metropolis	29·06	..	39·10	..	2·55	..
Liverpool	20·67	25·07	35·36	34·92	2·82	2·58
Sheffield	23·19	28·14	28·51	29·28	3·50	3·75
Manchester	22·86	27·37	40·76	39·93	2·45	2·50
Birmingham	23·70	26·82	48·65	50·63	2·06	1·97
Leeds	22·51	26·01	33·59	35·44	2·95	2·82
City of Exeter	30·56	26·24	39·88	41·79	2·50	2·39
Devon	37·97	31·48	57·14	66·57	1·75	1·50
Essex	30·82	28·55	51·12	56·34	1·95	1·77
Suffolk.	33·24	29·51	48·96	54·57	2·04	1·83
Norfolk	31·80	26·71	48·82	56·38	2·04	1·77
Hereford	38·42	30·54	57·86	68·49	1·72	1·46

This table contains some interesting results, and I beg to cite two cases. The average age at death in the metropolis is 29·06 years, but in the town of Sheffield it is only 23·19 years; however, if Sheffield were placed under the population of the metropolis the average age at death would be raised to 28·14 years, approaching close to the metropolis.

Another method of viewing this question would be to apply the same rate of mortality to different populations. The populations of the same place at different periods will be found to change in their distribution over the various periods of life, in the same way that distinct districts, as before noticed, do at the same period of time.

Neison on alcoholism

F.G.P. Neison (1851). On the rate of mortality among persons of intemperate habits. *J. Stat. Soc. Lond.* 14, 200-219.

From the age of sixteen upwards, it will be seen that the rate of mortality exceeds that of the general population of England and Wales. In the 6111.5 years of life to which the observations extend, 357 deaths have taken place; but if these lives had been subject to the same rate of mortality as the population generally, the number of deaths would have only been 110, showing a difference of 3.25 times. At the term of life 21-30, the mortality is upwards of five times that of the general community; and in the succeeding twenty years of life, it is above four times greater, the difference, as might be expected, gradually becoming less and less. If there be anything, therefore, in the usages of society calculated to destroy life, the most powerful is certainly the inordinate use of strong drink.

$$\text{SMR} = 3.25$$

Westergaard: method of expected number of deaths

H. Westergaard (1882). Die Lehre von der Mortalität und Morbilität. Jena: Fischer

Aufenthaltort.	Lebensjahre.	Gestorbene.	Erwartungsmässig Gestorbene nach den 3 speciellen Tafeln.	Gestorbene nach der Tafel des Königreichs.
Kopenhagen	7127	108	156	98
Provinzstädte	9556,5	159	183	143
Landdistricte	4213,5	74	53	60
Ganzes Land	20897,0	341	392	301

Man sieht hieraus, wie schwierig es ist, eine wissenschaftliche statistische Berechnung zu unternehmen. Die zwei Methoden dürften beide richtig scheinen, und doch geben sie ausserordentlich verschiedene Resultate. Nach der einen Methode würde man schliessen, dass der ärztliche Stand unter sehr ungünstigen sanitären Verhältnissen lebe, nach der anderen, dass der Gesundheitszustand verhältnissmässig gut sei.

Die Schwierigkeit lag darin, dass es zwei Ursachen gab: die ärztliche Profession und der Aufenthaltsort; beiden Ursachen muss man gerecht werden, und wenn man von der einen, dem Aufenthaltsorte, absieht und nur mit Hülfe der allgemeinen Sterblichkeitstafel den Einfluss der anderen betrachtet, begeht man einen fehlerhaften Schluss.

Am sichersten ist es, die Theilung des Materials fortzusetzen, bis es keine störende Ursachen mehr giebt; hat man keinen anderen Beweis, so wird man ein sicheres Kennzeichen, dass dies erreicht ist, darin finden, dass eine erneuerte Theilung des Materials nicht die Resultate ändert.

	Years at risk	Dead	Expected Number of Deaths according to	
			the 3 special districts	the whole country
Copenhagen	7127	108	156	98
Provincial towns	9556.5	159	183	143
Rural districts	4213.5	74	53	60
<hr/>				
Whole country	20897.0	341	392	301

It is seen from this how difficult it is to conduct a scientific statistical calculation. The two methods both look correct, and still yield very different results. According to one method one would conclude that the medical profession live under very unhealthy conditions, according to the other, that their health is relatively good.

The difficulty derives from the fact that there *exist two causes*: the medical profession and the place of residence; both causes have to be taken into account, and if one neglects one of them, the place of residence, and only with the help of the general life table considers the influence of the other, one will make an erroneous conclusion.

The safest is to continue the stratification of the material until no further disruptive causes exist; if one has no other proof, then a safe sign that this has been achieved, is that further stratification of the material does not change the results.

In Kopenhagen ist die Sterblichkeit etwas grösser gewesen, als im übrigen Dänemark, aber nicht so viel grösser, dass nicht zufällige Ursachen den Unterschied erklären könnten. Auf dem Lande ist die Sterblichkeit grösser, als erwartungsmässig, aber auch hier lässt sich nicht entscheiden, ob diese höhere Sterblichkeit einer verschiedenen Norm zuzuschreiben ist. Um dieses nun noch besser zu erkennen, können wir die Anzahl der erwartungsmässigen Todesfälle nach der Tabelle des Königreichs um 13,2 Procent erhöhen. Wir erhalten dann folgendes Resultat:

Aufenthaltort	Erfahrung	Berechnung
Kopenhagen	108	110,94
Provinzstädte	159	161,60
Landdistricte	74	68,50
Das ganze Land	341	341

Die Abweichungen sind so unwesentlich, dass man sie mit gutem Grunde als eine Wirkung zufälliger Ursachen betrachten kann, und man darf ohne grosses Risiko die Sterblichkeit in allen drei Landestheilen, wenigstens in Kopenhagen und den Städten, für gleich gross annehmen.

Wenn wir jetzt, wie wir es gelernt haben, irgend eine Ursache, z. B. das Alter, durch Anwendung der Methode der erwartungsmässig Gestorbenen eliminiren, so muss der mittlere Fehler die Form:

$$M = \sqrt{S \cdot p \cdot q \dots} \quad (43)$$

erhalten, wenn das Alter dadurch zu einer zufälligen Ursache reducirt worden ist; in der Formel (43) wird S die Anzahl der Lebensjahre, p die Wahrscheinlichkeit zu sterben und q die Wahrscheinlichkeit zu leben bedeuten. Aber in der That hat der mittlere Fehler die Form:

$$M = \sqrt{a_1 p_1 q_1 + a_2 p_2 q_2 + \dots} \quad (44)$$

Diese beiden Formeln werden indessen unter gewissen Voraussetzungen identisch. Wenn man z. B. berechtigt ist, q hinwegzunehmen, werden beide Ausdrücke für den mittleren Fehler zur Quadratwurzel der Gestorbenen reducirt. Mit Annäherung, aber auch nur mit Annäherung, wird also das Alter als eine zufällige Ursache betrachtet werden können. Wie mit dem Alter, so geht es mit allen anderen Factoren, die in die Sterblichkeit eingreifen, so mit den Vermögensverhältnissen, Erwerb, Wohnung, Kleidung u. s. w. u. s. w. — alle üben ihre Wirkungen, und es ist unmöglich sie gänzlich hinwegzuschaffen; selbst dann, wenn zwei Bevölkerungen auf dieselbe Weise, verhältnissmässig aus derselben Anzahl von Armen und Reichen, Trunkenbolden und Nüchternen, zusammengesetzt sind, werden doch alle diese Ursachen vorhanden sein, und es ist nur eine Annäherung an die Wahrheit, wenn man davon spricht, dass sie eliminirt sind, eine Annäherung, deren Berechtigung mehr oder minder auf subjektivem Ermessen beruht.

Standard error of the expected number of deaths

If we now, as we have learnt about it, have eliminated some cause, e.g. age, through application of the method of expected number of deaths, then the standard error will take the form

$$M = \sqrt{S \cdot p \cdot q}$$

since age has been reduced to a random cause.

[random cause: zufällige Ursache]

Standard error of SMR reinvented by Yule (1934).

Yule: Association measures

(Galton-)Pearson correlation coefficient was forcefully marketed by Karl Pearson

G.U. Yule (1900). On the association of attributes in statistics: with illustrations from the material of the Childhood Society, &c. *Phil.Trans.Roy.Soc.Lond. A*, **194**, 257-319.

2×2 table

a	b
c	d

define $Q = \frac{ad - bc}{ad + bc}$

As the correlation coefficient, $Q = 0$ under independence, $= \pm 1$ under total positive/negative dependence.

Note for later use: $Q = \frac{OR - 1}{OR + 1}$ where OR is the odds ratio

(Pearson preferred the tetrachoric correlation generated by assuming double dichotomy of a bivariate normal. Yule and Pearson fought about this for more than a decade, cf. MacKenzie (1978, 1981).)

Example: association between smallpox vaccination and attack rate

Town.	Date.	Attack rate under 10.		Attack rate over 10.	
		Vaccinated.	Unvaccinated.	Vaccinated.	Unvaccinated.
Sheffield	1887-88	7·9	67·6	28·3	53·6
Warrington	1892-93	4·4	54·5	29·9	57·6
Dewsbury	1891-92	10·2	50·8	27·7	53·4
Leicester	1892-93	2·5	35·3	22·2	47·0
Gloucester	1895-96	8·8	46·3	32·2	50·0

Association between Non-vaccination and Attack in Infected Households.

Town.	Children under 10.	Persons over 10.
Sheffield	·92	·49
Warrington	·93	·52
Dewsbury	·80	·50
Leicester	·91	·51
Gloucester	·80	·36

Notice the widely differing attack rates for Sheffield, Warrington, Leicester, but quite similar values of Q .

Kermack, McKendrick, McKinlay: multiplicative age-cohort model for death rates

W.O. Kermack, A.G. McKendrick, P.L. McKinlay (1934). Death-rates in Great Britain and Sweden: expression of specific mortality rates as products of two factors, and some consequences thereof. *J. Hygiene (Camb.)* **34**, 433-457.

Death-rate at age θ and time t may be described by

$$f(t, \theta) = \alpha(t, \theta) \beta_{\theta}$$

The paper contains careful discussion of estimation procedures (with standard errors) and goodness of fit evaluation.

There is no reference to the lively current discussion of standardization.

Until 1979 this paper was not quoted outside a narrow circle of cohort analysts.

DEATH-RATES IN GREAT BRITAIN AND SWEDEN:
 EXPRESSION OF SPECIFIC MORTALITY RATES
 AS PRODUCTS OF TWO FACTORS, AND SOME
 CONSEQUENCES THEREOF

BY W. O. KERMACK, A. G. MCKENDRICK
 AND P. L. MCKINLAY

*From the Laboratory of the Royal College of Physicians of Edinburgh,
 and the Department of Health for Scotland*

(With 6 Figures in the Text)

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INTRODUCTION

In a preliminary paper¹ the specific death-rates of England and Wales, of Scotland, and of Sweden of the various age groups for different years have been analysed, and the chief result which emerged may be stated in the following terms. If $v_{t,\theta}d\theta$ denote the number of persons at a time t , between the ages θ and $\theta + d\theta$, then²

$$-\frac{1}{v_{t,\theta}} \left(\frac{\partial v_{t,\theta}}{\partial t} + \frac{\partial v_{t,\theta}}{\partial \theta} \right) = f(t, \theta) \quad \dots\dots(1)$$

is the specific death-rate for the age θ at the time t . It appears from our previous paper that $f(t, \theta)$ may, to a close approximation, be represented as the product of two factors, of which one, β_θ , is a function of the age alone, whilst the other, $\alpha(t-\theta)$, is a function of the date of birth ($t-\theta$). Thus

$$f(t, \theta) = \alpha(t-\theta) \beta_\theta \quad \dots\dots(1a).$$

Clearly both α and β are arbitrary to the extent of a multiplying constant. In the case of the statistics of England and Wales, and of Scotland, the deviations from this form appear to be of the nature of random irregularities,

SUMMARY

1. The specific mortality rates for males, females and the total population for England and Wales, for Scotland and for Sweden, have been fitted to a formula $f(t, \theta) = \alpha(t - \theta) \beta_\theta$, where $f(t, \theta)$ is the specific mortality rate at a time t for age θ , β_θ is a function depending solely on the age θ , and $\alpha(t - \theta)$ depends only on the time of birth ($t - \theta$). The results are in substantial agreement with those obtained by less refined methods in the previous paper. The probable errors of the values found for α and for β have been calculated.

2. It is shown that the β_θ curves for the Scottish and the English males are approximately represented by the Makeham-Gompertz formula $A + Be^{c\theta}$, where A , B and c have suitable values. The other β_θ curves do not appear to conform exactly to a formula of this type.

3. With the help of the representation of β_θ by the Makeham-Gompertz expression the effect of variation of α on the survival curves, the death curves, and the expectation of life has been determined. It is shown that with the range of values of α experienced in Britain during the last 50 years, the most marked effect is most likely to be experienced in the future between the ages of 65 and 85, a very considerable increase of people of these ages being likely provided that the relationship exhibited by the statistics up to the present date is maintained in the future.

Though the Makeham-Gompertz formula does not hold in the case of the English and Scottish females, nor for the Swedish statistics, these approximate sufficiently closely to the values for the English and Scottish males, to allow of the conclusion deduced in the latter case being extended to the former.

4. It is strongly emphasised that the validity of all the predictions depends upon a hypothesis of extrapolation which, however attractive in the light of the figures so far available, might not be fulfilled under certain contingencies.

Kitagawa-decomposition of rate-differences

E.M. Kitagawa (1955). Components of the difference between two rates. *JASA* **50**, 1168-1174.

$$\text{Crude rate}^A - \text{Crude rate}^S = \sum a_i \alpha_i - \sum s_i \lambda_i$$

$$= \sum (a_i - s_i) \frac{\alpha_i + \lambda_i}{2} + \sum (\alpha_i - \lambda_i) \frac{a_i + s_i}{2}$$

= difference in	weighted	difference in	weighted
age distribution	with average	age specific	with average
	age specific	death rate	age distribution
	death rate		

= contribution from difference in age distribution + contribution from difference in pattern of death rates

Miettinen: Components of the crude risk ratio

Amer. J. Epid. **96** (1972), 168-172

	exposed	non exposed	
Cohort study	Events	e_j	g_j
	Denominator (No. individuals or person-years)	F_j	H_j

$j = 1, \dots, k$

$$e = \sum e_j, F = \sum F_j, g = \sum g_j, H = \sum H_j,$$

$$\text{Crude risk ratio } \hat{\rho}_c = \frac{e}{F} \bigg/ \frac{g}{H} = eH / gF$$

Under no effect in stratum j , e_j would be $e_j^* = g_j F_j / H_j$ (expected no. of events in the exposed if non-exposed rates applied) so with $e^* = \sum e_j^*$, the component of $\hat{\rho}_c$ attributable to confounding would be

$$\hat{\rho}^* = e^* H / gF$$

Components of the crude risk ratio

Repeat: component of $\hat{\rho}_c = eH/gF$ due to confounding is

$$\hat{\rho}^* = e^* H/gF$$

Rate ratio cleaned of confounding by direct standardization based on stratification in the exposed group

$$\hat{\rho}_s = e/e^*$$

and we have

$$\hat{\rho}_c = \hat{\rho}^* \cdot \hat{\rho}_s$$

due to due to
confounding exposure

Mantel and Haenszel

N. Mantel & W. Haenszel (1959). Statistical aspects of the analysis of data from retrospective studies of disease. *J. Nat. Cancer Inst.* **32**, 719-748.

Stratify 2×2 table into $2 \times 2 \times k$ table

$$\begin{array}{cc} A_i & B_i \\ C_i & D_i \end{array}, i = 1, \dots, k$$

Use as a “summary estimate of the relative risk”

$$\frac{\sum A_i D_i / (A_i + B_i + C_i + D_i)}{\sum B_i C_i / (A_i + B_i + C_i + D_i)}$$

which makes sense in a model with odds ratios (or Yule's Q) constant across strata.

Likewise, the famous one-degree of freedom Mantel-Haenszel test for unity relative risks can be explained by first assuming common odds ratio, the testing whether this = 1.

Mantel & Haenszel on the Mantel-Haenszel procedure

If one could assume that the increased relative risk associated with a factor was constant over all subclassifications, the estimation problem would reduce to weighting the several subclassification estimates according to their respective precisions. The complex maximum likelihood iterative procedure necessary for obtaining such a weighted estimate would seem to be unjustified, since the assumption of a constant relative risk can be discarded as usually untenable.

The Standardized Mortality Ratio as maximum likelihood estimator

S.J. Kilpatrick (1962). Occupational mortality indices. *Population Studies* **16**, 175-187.

Occupational Mortality Indices*

By S. J. KILPATRICK

INTRODUCTION

The detection of associations between environment and specified causes of death often provides important clues to the ætiology of fatal disease. The mortality experienced by different groups of individuals is best compared, using specific death rates of sub-groups alike in every respect, apart from the single factor by which the total population is divided. This situation is rarely, if ever, realised and we have to be satisfied with mortality comparisons between groups of individuals alike with regard to the two, three or four major factors known to affect the risk of death.

In this paper groups are defined as aggregates of occupations (social classes). It is assumed that age is the only factor related to an individual's mortality within a group. This example may readily be extended to other factors such as sex, marital status, residence, etc. Although the association of social class and age-specific mortality may be evaluated by comparisons between social classes, specific death rates of a social class are more frequently compared with the corresponding rates of the total population. It is this type of comparison which is considered here.

Derivation of Weights

Weights which minimise the variance of I_{us} may be derived as follows. Assume that the θ_x are homogeneous and that M_{ux} may be used as the risk of death from the cause specified.⁸ Then θM_{sx} is the probability of death in group u between the ages x and $x+n_x$ and the logarithm of the likelihood of the observed series of deaths D_{ux} is

$$L = \text{constant} + \Sigma D_{ux} \log (\theta M_{sx}) + \Sigma (P_{ux} - \frac{1}{2} D_{ux}) \log (1 - \theta M_{sx})$$

$$\text{Hence } \frac{\partial L}{\partial \theta} = \Sigma \frac{D_{ux}}{\theta} - \Sigma \frac{(P_{ux} - \frac{1}{2} D_{ux}) M_{sx}}{(1 - \theta M_{sx})}$$

To the first order of θ , $\frac{1}{2} D_{ux}$ may be neglected relative to P_{ux} , and θM_{sx} relative to 1, so that an approximate solution of the maximum likelihood equation $\frac{\partial L}{\partial \theta} = 0$ is

$$\hat{\theta} = \frac{\Sigma P_{ux} M_{ux}}{\Sigma P_{ux} M_{sx}} = \frac{D_u}{E_u}$$

This first-order estimate of θ is easily recognised as the usual expression for the S.M.R., being the ratio of the total observed deaths in group u to the total deaths expected in group u by indirect standardisation.⁹ Therefore, the "best" system of weights (in the sense of *iv*) is that equal or proportional to P_{ux} , the age structure of the group u . It follows that the S.M.R. has the smallest standard error of all mortality indices defined by (1).

The variance of $\hat{\theta}$ may be obtained from the second derivative's expectation by

$$\begin{aligned}
 (\text{Var } \hat{\theta})^{-1} &= -E \left\{ \frac{\partial^2 L}{\partial \theta^2} \right\} \\
 &= \frac{\Sigma D_{ux}}{\hat{\theta}^2} + \Sigma \frac{(P_{ux} - \frac{1}{2} D_{ux}) M_{sx}^2}{(1 - \hat{\theta} M_{sx})^2} \\
 &= \frac{E_u^2}{D_u} + \Sigma E_{ux} M_{sx} \dots \dots \dots (3)
 \end{aligned}$$

neglecting terms of higher order.

Taking the reciprocal gives D_u/E_u^2 as a slightly overestimated minimum variance. This, however, is the conventional expression used to estimate the variance of the S.M.R. and is easily derived from (2) by substitution of $w_x = P_{ux}$.

This paper proposes a simple test for heterogeneity in θ_x and shows that the S.M.R. is equivalent to the maximum likelihood estimate of a common θ when the θ_x do not differ significantly. It follows therefore that the S.M.R. has a minimum standard error.

The National Halothane Study

J. Bunker, W. Forrest Jr., F. Mosteller & L. Vardam (eds.) (1969). *The National Halothane Study*. National Institute of General Medical Sciences.

Halothane is an anaesthetic which around 1960 was suspected in the U.S. for causing increased rates of hepatic necrosis, sometimes fatal. A large cooperative study was started in July 1963. We shall here focus on the study of ‘surgical deaths’, i.e. deaths during the first 6 weeks after surgery. The study was based on retrospective information from 34 participating medical centres, who reported all surgical deaths during the four years 1959-62 as well as provided information on a random sample of about 38,000 from the total of about 856,000 operations at these centres during the four years. The study was designed and analysed in a collaborative effort between leading biostatisticians at Stanford University, Harvard University and Princeton University/Bell Labs and the report (Bunker et al., 1969) is unusually rich in explicit discussions about how to handle the adjustment problem with the many variables registered for the patients and the corresponding ‘thin’ cross-classifications.

The National Halothane Study: introduction by B.W. Brown et al.

‘the analysis of rates and counts associated with many background variables is a recurring and very awkward problem. ...It is appropriate to create new methods for handling this nearly universal problem at just this time. **High-speed computers and experience with them have now developed to such a stage** that we can afford to execute extensive manipulations repeatedly on large bodies of data with many control variables, whereas previously such heavy arithmetic work was impossible. The presence of the large sample from the National Halothane Study has encouraged the investigation and development of flexible methods of adjusting for several background variables. Although this adjustment problem is not totally solved by the work in this Study, substantial advances have been made and directions for further profitable research are clearly marked.’

The National Halothane Study: introduction by B.W. Brown et al. (cont.)

‘Pure or complete randomization does not produce either equal or conveniently proportional numbers of patients in each class; attempts at deep post-stratification are doomed to failure because for several variables the number of possible strata quickly climbs beyond the thousands.

...

Insofar as we want rates for special groups, we need **some method of estimation that borrows strength from the general pattern of the variables**. Such a method is likely to be similar, at least in spirit, to some of those that were developed and applied in this Study.

At some stage in nearly every large-scale, randomized field study (a large, randomized prospective study of postoperative deaths would be no exception), the question arises whether the randomization has been executed according to plan. Inevitably, adjustments are required to see what the effects of the possible failure of the randomization might be. Again, the desired adjustments would ordinarily be among the sorts that we discuss.’

The National Halothane Study: methods

Many versions of standardization (L. Moses, J.W. Tukey et al.)

'Smoothed' contingency table analysis (F. Mosteller, Y.M.M. Bishop) leading to the important monograph

Y.M.M. Bishop, S.E. Fienberg & P. Holland (1975). *Discrete Multivariate Analysis: Theory and Practice*. MIT Press, Cambridge, MA.

Loglinear models

S.E. Fienberg (1975). Comment [on paper by Sonja McKinley], *JASA* **70**, 821-823.

The reader should be aware that standardization is basically a descriptive technique that has been made obsolete, for most of the purposes to which it has traditionally been put, by the ready availability of computer programs for loglinear model analysis of multidimensional contingency tables.

Inverse probability weighting: ghosts

B.W. Turnbull (1976). The empirical distribution function with arbitrarily grouped, censored and truncated data. *JRSS B* **38**, 290-295.

Also, because of the truncation, each observation $X_i = x_i$, can be considered a remnant of a group, the size of which is unknown and all (except the one observed) with x -values in B_i^c . (They can be thought of as X_i 's "ghosts".)

Weighting methods today: time-dependent confounding

Conventional wisdom on confounders and intermediate variables

exposure → response



confounder

Control for confounder

exposure → response

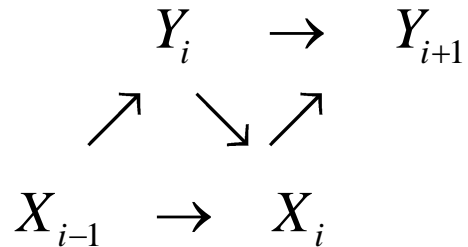


intermediate variable

Do not control for intermediate variable

Time-dependent confounders, *or* feed-back

Feed-back from outcome Y_i to covariate X_i



Y_i intermediate between X_{i-1} and Y_{i+1}
so do not condition on Y_i

Y_i confounder for effect of X_i on Y_{i+1}
So “control” for Y_i e.g. by conditioning

Robins: g-computation, marginal structural models

J.M. Robins (1986). A new approach to causal inference in mortality studies with a sustained exposure period – application to control of the healthy worker survivor effect. *Math.Modell.* **7**, 1393-1512.

J.M. Robins, M.A. Hernán, B. Brumback (2000). Marginal structural models and causal inference in epidemiology. *Epidemiology* **11**, 550-560.

R.M. Daniel et al. (2013). Methods for dealing with time-dependent confounding. *Statist. Med.* **32**, 1584-1618.

Robins (1986) generalized direct standardization to the time-dependent confounding situation and formulated other approaches using inverse probability weighting such as marginal structural models (2000). A very readable survey is by Daniel et al. (2013).

The target is here *marginal*, at least within strata, and to me this seems a major reason why marginal effect measures and direct standardization methods are back in business.

(Note: Robins et al. also studied conditional targets via *structural nested models*).

Simplest possible marginal structural model

Effect of dichotomous exposure E on dichotomous outcome D

covariates z_1, \dots, z_k . Assume no unmeasured confounders

given observation of $z_i : P(D = 1 | \text{set } E = e, Z = z_i) = P(D = 1 | E = e, Z = z_i)$.

Marginal structural model

$$P(D = 1 | \text{set } E = e) = e^{\beta_0 + \beta_1 e}$$

Estimation via Inverse Probability of Treatment Weights (IPTW).

Each subject j with covariate z_j and exposure e_j is assigned a weight

$$w_j = 1 / P(E = e_j | Z = z_j)$$

Let exposed \sim Study group, unexposed \sim Standard group. Then if $z_j = 1$

$$P(E = 1 | Z = i) = A_i / (A_i + S_i), \quad P(E = 0 | Z = i) = S_i / (A_i + S_i)$$

Derivation of IPTW estimator

$$\begin{aligned} P(D = 1 | \text{set } E = e) &= \sum_z P(D = 1 | E = e, Z = z) P(Z = z) && \text{(no unmeas. conf.)} \\ &= \sum_z \frac{P(D = 1, E = e, Z = z) P(Z = z)}{P(E = e | Z = z) P(Z = z)} \\ &= \sum_z \frac{P(D = 1, E = e, Z = z)}{P(E = e | Z = z)} \end{aligned}$$

each individual is weighted with the Inverse Probability of being exposed (Treated).

Direct and Indirect Standardization in terms of target population

T. Sato & Y. Matsuyama (2003). Marginal structural models as a tool for standardization. *Epidemiology* **14**, 680-686.

Study (exposed) Population Target:

$$SMR = \sum A_i \alpha_i / \sum A_i \lambda_i$$

compare observed no. deaths to counterfactual no. of deaths if unexposed

Standard (unexposed) Population Target:

$$CMF = SRR = \sum S_i \alpha_i / \sum S_i \lambda_i$$

compare counterfactual no. deaths if exposed to observed no. deaths.

Third possibility: *Total Population Target:*

$$SRR_T = \frac{\sum (A_i + S_i) \alpha_i}{\sum (A_i + S_i) \lambda_i} = \frac{\sum A_i \alpha_i / (A_i / (A_i + S_i))}{\sum S_i \lambda_i / (S_i / (A_i + S_i))}$$

Total Population Target: Interpretation

$$SRR_T = \frac{\sum (A_i + S_i) \alpha_i}{\sum (A_i + S_i) \lambda_i} = \frac{\sum A_i \alpha_i / (A_i / (A_i + S_i))}{\sum S_i \lambda_i / (S_i / (A_i + S_i))}$$

$$= \frac{\sum (\text{deaths in Study Population in age group } i) / (A_i / (A_i + S_i))}{\sum (\text{deaths in Standard Population in age group } i) / (S_i / (A_i + S_i))}$$

numerator: for each age group I , deaths in study population weighted with inverse probability of being in study population

denominator: for each age group I , deaths in standard population weighted with inverse probability of being in standard population

Likelihood interpretation of continuous-time marginal structural models

K. Røysland (2011). A martingale approach to continuous-time marginal structural models.
Bernoulli **17**, 895-915

Defines two martingale measures:

the observational measure

the randomised trial measure

and assumes the latter absolutely continuous wrt the former.

The resulting likelihood ratio process corresponds to the weights in discrete time marginal structural models.

Summary

Weighting and standardization

1777-1900 Prehistory

much discussion that I have skipped

1955 Kitagawa

1959 Mantel & Haenszel

1972 Miettinen

1976 Turnbull: ghosts

1986 Robins: time-dependent confounding

1999 Robins: marginal structural models

Models and parameters

(Pearson correlation)

1900 Yule: association measure Q

1934 Kermack, McKendrick, McKinlay
Multiplicative model for rates

1962 Kilpatrick: SMR as MLE

1969 The National Halothane Study

1960s Loglinear models, logistic regression

1972 Cox

1970s, 1980s Models can solve everything

Epilogue

To most biostatisticians the conditional approach (stratification, regression analysis) is the preferred one for the daily work analysing observational studies. BUT more complex situations have shown that the parameters of logistic and multiplicative intensity models no longer have interpretation as causal effects (*e.g.* Aalen et al., 2015). This has brought the marginal approach back into the limelight, most spectacularly with the breakthrough by Robins (1986) on time-dependent confounding.

Aalen, O.O., Cook, R.J. & Røysland, K. (2015). Does Cox analysis of a randomized survival study yield a causal treatment effect? *Lifetime Data Analysis* **21**, 579-593.