Correspondence

The pathology of family life

Sir,

I would like to comment on some questions raised by Dr D. L. Williams' article *The pathology of family life*[1], and to disagree with his suggestion that "social class is fundamentally determined by the degree of independence and responsibility the family is prepared or expected to adopt in the management of its own affairs". If this to me quite fantastic remark were just an aside in an article devoted to some other topic, one could ignore it, but Dr Williams refers frequently to social factors and in view of this extraordinary definitition of his I find it difficult to interpret the whole article. The concept of social class even when it is based on the rather primitive definitition of the Registrar General related to occupational skill, is an extremely useful social and epidemiological tool. Its usefulness depends entirely on the fact that its classification is based on objective criteria. To replace this by any subjective assessment such as the doctor's opinion of the degree of independence and responsibility a family shows, would altogether invalidate any work based on it. I wonder how Dr Williams would classify a family living on a private estate, sending its children to private schools, providing for its own retirement, and employing a private doctor, whose private income was derived entirely from the interest on invested capital? Does he think living from an unearned income represents a high degree of independence and responsibility?

Much more to the point is whether the present Registrar General's classification is satisfactory. There will always be anomalies in such classifications, because the relation of different social groups (I think this term is preferable to social class, which implies quite different economic and social categories) varies a great deal from decade to decade. An example was the re-classification of miners after the war into social class three, as a skilled occupation. It has always seemed to me that this reflected much more the changed attitude to miners on the part of many professional people, or at least those concerned with the Registrar General's classification, than any real change in the miners' social and economic environment in comparison with other social groups. It has resulted in the very large number of day-wage men working underground and on the surface, many of whom take home wages of under £12 a week, sometimes substantially so, being classified with skilled artisans. It is doubtful if this is justified even in the case of the better-off hewers and getters at the coal face, for while their wages tend to be fairly high, theirs is an age-related sub-group within the over-all occupation of mining; the highly paid face worker is forced by age or injury into the badly paid day-wage category somewhere at or before middle life. In addition to this, the considerable skills required in mining are almost completely non-transferable to other

industries and in practice miners forced out of the industry are having to find unskilled labouring occupations. It is quite clear to me, and other doctors who work in them, I think, that social and medical problems in the present or former mining areas of Britain are very acute and obviously are likely to worsen. In Wales at least these are areas of high mortality and also of high general practitioner work-load, and have been the object of concern by the Ministry of Health. It seems to me most unfortunate that the apparent misclassification of miners by the Registrar General may distort this mortality and other epidemiological data. I do not know whose job it is to try to influence these decisions, but I should have thought that the College could reasonably make representation in the matter as we are certainly an interested body.

I also think that so far as possible the *Journal of the Royal College of General Practitioners* should encourage its contributors to present their work in an objective, definable and if possible measurable fashion, so that hypotheses and conclusions can be discussed in a scientific manner. We have surely long ago left the era of unconfirmable and undeniable subjective speculation and assertion.

Glyncorrwg. J. TUDOR HART.

REFERENCE

1. J. roy. Coll. gen. Practit. (1967).

General practice in South-west England

Sir,

The survey on general practice in South-west England is based on a mass of very interesting and important information devotedly recorded by the 68 participating doctors. Yet the report itself is in some ways disappointing.

Nature carries out research by throwing up occasional variants and selecting those most efficient for the development of the species. In contrast, the results of this survey are presented in such a way as to bury all variants in the means of the groups selected for comparison. This is an excellent technique for presenting information on the *status quo* but provides almost no clues as to how general practice could be improved in the future.

For example, the consultation rate per 1,000 patients at risk annually is quoted as ranging from 1,997 to 8,263 (1:4.14). Yet of all the 23 groups chosen in tables I and II the widest range is from 3,427 (practitioners with 3,000 or more patients) to 4,784 (practitioners with less than 2,000 patients), a ratio of 1:1.40. The report concludes that "this suggests that individual reports from practices are of limited value". What greater value emanates from 23 groups with almost identical average rates? "Plainly the doctor himself is a major factor in the determination of his consultation rate" but no evidence is adduced to support the sweeping and pessimistic assertion that "this appears to be due to subtle and intangible elements in patient relationship rather than to any readily alterable factors". I suggest that the views of "Doctor 1,997" and "Doctor 8,263"