disease could draw their attention to the formation of this society and put them in touch with Mrs Elizabeth Segall, 116 Loudoun Road, London, N.W.8.

Lichfield. J. D. W. WHITNEY.

Use of vitamin D

Sir,

Little is known of the effects on the infant of large therapeutic doses of vitamin D given to the mother during pregnancy. I have been able to follow the development of children born to a mother with postoperative hypoparathyroidism who was treated with large doses of calciferol during pregnancy and have found defects in two of them. It is tempting to attribute the abnormalities to the toxic effects of this vitamin but I have, as yet, no proof.

Further cases are difficult to find as unphysiological doses of vitamin D are only likely to be given in pregnancy for hypocalcaemia and certain metabolic bone diseases. I should like to hear from any of your readers who know of pregnancies during which large doses of vitamin D have been given so as to compare my experience with theirs.

1 Fleethall Grove,
Stifford Clays,
Grays, Essex. R. N. HERSON.

The pathology of family life

Sir,

Dr J. Tudor Hart[1] is mistaken when he imagines that, in my address "the pathology of family life",[2] I proposed to replace the Registrar General's classification of social class by some new subjective classification of my own. All classifications arrange social classes or groups in order of rank and I was discussing the criteria which society uses to 'rank' the familial attitudes characteristic of social classes.

When Dr Hart asks whether I think living from an unearned income 'represents' a high degree of independence and responsibility he invites me to make a personal value judgment. What really matters is not whether the order of rank I described conforms to his values or to mine but whether it reflects the values commonly held by the society in which we live. It is a fact that a large unearned income endows a family with a high degree of financial independence and that society expects such a family to accept a high degree of financial responsibility for its own affairs. Moreover, independence and responsibility are not only financial. Educational advantages confer a degree of independence and impose corresponding responsibilities. The status attached to certain occupations, paid or unpaid, can have the same effect but, even if society today values a purely

financial independence less than formerly, I question whether the change has been as great as either of us would wish.

Indeed, the very existence of social class is, to most of us, an unwelcome fact of life. Although it may well be more comfortable to restrict discussion to the Registrar General's statistical comparison of occupational groups, it is surely wrong to pretend that more fundamental issues do not exist or cannot even be discussed until they somehow become " objective, definable and, if possible, measurable ".

Holywell, Flintshire. DAVID L. WILLIAMS.

1. *J. roy. Coll. gen. Practit.* (1968) **15**, 301.
2. *J. roy. Coll. gen. Practit.* (1967) **14**, 249.

Book Reviews

Custom and practice in medical care. J. SIMPSON, A. MAIR, R. G. THOMAS, H. N. WILLARD, H. J. BAKST. Published for Nuffield Provincial Hospital Trust. London, New York, Toronto. Oxford University Press. 1968. Pp. 120. Price 12s. 6d.

The increasingly escalating costs of medical treatment make it not only impossible for the patient to provide for his own medical care under all circumstances, but also makes it more difficult and costly for the doctor to undertake advanced medical care (including diagnosis) in his typical surgery or consulting rooms. Similarly, the shortage of doctors makes it increasingly more difficult for two or more doctors to care for one patient when one doctor could do the lot, provided he was given the facilities.

In the National Health Service, the first problem has been solved more satisfactorily though possibly not ideally, whilst the second one is aggravated by our present administrative procedure, where the clinical responsibility for the care of a patient is transferred backwards and forwards between various doctors, often impeded by inadequate communications.

In the medical set up in the U.S.A. the first problem of cost in relation to the availability of medical care remains but the second problem has been taken care of by the accredited doctor to the hospital who can continue to look after his patient throughout the whole course of the majority of illnesses. How this works out has been imaginatively illustrated by a concise crisp study, published for the Nuffield Provincial Hospital Trust in 120 pages. It will be necessary some day for someone to assess the tremendous value towards progress stimulated by the Nuffield Provincial Hospital Trust and its sister foundation. Here, in a succinct way, the polemics of the antagonists and protagonists of the N.H.S. are put in the proper perspective by taking two communities, one in the U.K. and one in the U.S.A., and comparing their hospital admission and hospital discharges. The two communities under examination are Arbroath in Scotland and Waterville, Maine, U.S.A. Both have sufficient in common to be demographically and sociologically comparable. Of course there are many imperfections inherent in such a study, but the team seem to have been very conscious of the many pitfalls, and have avoided glib generalizations.

Such a medical audit is desirable and necessary if we are to base our planning