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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Eugenics and the Registrar General

SIR,—Dr Iain Chalmers is to be congratulated for drawing attention to the problem of social class differences in fetal and neonatal mortality (27 July, p 231).

May I comment on some historical issues raised by the paper? The Registrar General's division of the population into social status groups, together with the accompanying pioneer fertility inquiries of the 1911 census, was probably not the brainchild of T H C Stevenson, with whom the origin of this classification is often associated. The architect of this undertaking was, arguably, the Registrar General, Bernard Mallet, himself.

Evidence of Stevenson's theory of society has proved difficult to locate.[1] By contrast, Mallet's social views are well documented.[2,3] In the context of fears after the Boer war over the quality of future generations and possible "race suicide" Mallet, the future president of the Eugenics Society, was concerned with the problem of differential fertility. He believed that social inequality was determined by inherent and unalterable genetic differences rather than unequal environmental circumstances and opportunities. The underlying purpose behind the creation of a social class classification was the desire to test hereditary assumptions and differential fertility patterns.[4,5] Data on fertility in different occupational groups that emerged from the 1911 census reinforced the eugenic belief in the need to restrict the multiplication of the lower social classes, referred to by Mallet as "the greatest purveyors of social inefficiency, prostitution, feeblemindedness and petty crime, the chief architects of slumdom, the most fertile strain in the community."[6] It confirmed his conviction that "the most important aims of our Eugenics Society are founded on statistics such as these."[7]

The combination of occupations into groups in terms of general economic and social circumstances marked the beginning of systematic analysis of differences in mortality among social classes. As Richard Titmuss showed in his classic study of social inequality and infant mortality, statistics of occupational fertility used in conjunction with those of infant mortality provided information on social class mortality.[8] But the social construction of occupational groupings, as introduced in the 1911 census, had more insidious eugenic intentions than belonged to a simple interest in social class gradients of occupation, mortality, and infant mortality. Analyses of social class differences in infant mortality, at least in the early years of this century, were inextricably linked with the problems of differential fertility and pronatalism, and thus with questions of physical fitness, national efficiency, and racial decay.[9] New measures that emerged to reduce infant and childhood morbidity and mortality were "aimed at raising the racial level of future generations."[10]

The emphasis on "maternal capability," which explains that relative differences in early mortality can be accounted for by social class differences among people who are "differently endowed [genetically] with certain personal attributes bearing on their ability to deal with their environment," is hardly new.[11] "Ignorance of the mother" as the "principal operating influence" in causing infant mortality in lower social classes was widely accepted in the early decades of this century by many, including Sir George Newman, chief medical officer to both the Board of Education and the local government board (from 1919 the Ministry of Health).[12] The fact that infant mortality was highest in the poorest parts of the large cities failed to convince officials that there was any connection between the two. Instead, by 1916 it was widely held to be indisputable that infant mortality was due more to the inherent inability of the poorer classes to cope with their external environment than to the conditions of the environment itself.[13]

The persistence of a gradient in the risk of mortality between the different social classes has often given rise to the suggestion that any movement up and down the social scale is "selective in terms of physical and intellectual qualities."[14] This, it has been contended, maintains the social class differences in terms of those "qualities" that have a significant effect on infant mortality.[15]

Chalmers underlines the important differences in the practical consequences of two competing theories. His own viewpoint, as he says, allies him with those who seek the distribution of both medical and social care according to need and improvements in the environmental circumstances of the less well off sections of the community. This admirable sentiment is diametrically opposed to the underlying purpose of Bernard Mallet's introduction of social class classification in 1911.

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