Obituary

Dr J. M. HUNTER, M.D., F.R.C.G.P.

Dr J. M. Hunter died in hospital in Belfast on 17 September, 1973 at the age of 75.

Joseph Molyneaux Hunter was a member of the First Council of the College and continued a member of Council until 1964. With the late Dr J. Campbell Young of Belfast (who was a member of the Foundation Council) he was largely responsible for starting the Northern Ireland Faculty of the College. He was secretary of the Faculty Board for the first five years of its existence, Provost in 1959–60, and a member of the Faculty Board until two years ago.

He was always glad to foster professional co-operation throughout Ireland, and in particular between the four Irish Faculties of the College. An influential member of the steering committee that worked for the setting up of Irish Council of the College, he was the first chairman of Irish Council in 1962 and a member of that Council with very few breaks until quite recently. He was one of the first Fellows of the College.

Educated at the Royal Belfast Academical Institution, on leaving school he served in the infantry in France in the latter years of the 1914–18 war. He was severely wounded, and discharged as permanently incapable. He studied medicine at Queen's University, Belfast, graduating M.B., B.Ch., B.A.O. in 1924 and proceeding to M.D. in 1929. He was in general practice in Portrush, Co. Antrim for over 20 years, and was Coroner for North Antrim.

In 1948, at the beginning of the National Health Service Dr Hunter left general practice to become Medical Adviser to the Northern Ireland General Health Services Board. In this office he came to know personally every general practitioner in Northern Ireland, and through his wide knowledge of the medical profession and the practice of medicine, combined with his wisdom and concern for doctors and patients, he made a contribution to the working of the Health Service in Northern Ireland of which the value cannot be overestimated. He was appointed an Honorary Physician to the Queen in 1953. Dr Hunter played a prominent part in the British Medical Association. For a number of years he was Honorary Secretary of the North-East Ulster Division and subsequently he was President of the Northern Ireland Branch, and was elected a Fellow of the British Medical Association and a Fellow of the Ulster Medical Society. An active member of the British Legion, he was President of the Queen's University Services Club in 1957.

He had an incisive but kindly sense of humour and was an excellent after-dinner speaker.

Dr Hunter retired in 1965, but until his short final illness he kept up his great interest in medical affairs. In his post with the Health Services Board he had been responsible for the organisation of postgraduate education for general practitioners and he followed with interest and satisfaction the great expansion that has taken place in this field in recent years, serving on the University Board for Postgraduate Medical Education. He often took the chair at lectures in the Belfast postgraduate centre and was frequently to be seen in the centre.

He never forgot his years in practice in Portrush, where he is still remembered with gratitude and affection by his former patients. In him, kindness and a sense of humour were joined with firmness of purpose and complete integrity. Among fellows and members of the College he will long be remembered for the part he played in the foundation of the Northern Ireland Faculty and in guiding its early years, and for his continuing contribution to the work of the College.

R. P. MAYBIN

CORRESPONDENCE

TESTS FOR BACTERURIA

Sir,

With reference to Mr Sendak's criticism, Mr A. Nicol of the Scottish General Practitioner Research Support Unit has made the following comments with which I agree:

"It is surprising that the discussion of false positives and false negatives did not alert Mr Sendak to the fact that tables such as his were drawn up but not used. Tables 1 and 4 are the important ones whilst tables 2 and 3 play supporting roles only. Mr Sendak's table is really a combination of tables 1 and 3 to provide a better presentation of table 2 from the statistical viewpoint. A comparison of the 'Uricult' results obtained in general practice with those in the laboratory (where it would not normally be used) is not really the object of the study. The only

really 'acceptable' number of false negatives is zero and it has been demonstrated that this is possible with 'Uricult' in general practice, given incubators and recommended times and temperatures, but most unlikely ever to be achieved with 'Uriglox.'

An important criticism of Mr Sendak's approach is that, apart from being no more revealing, it adopts laboratory poured-plate tests as an absolute criterion and we have shown that this is not necessarily the case. Perhaps the text should have retained the term 'important discrepant results' or at least qualified the term used by the addition of the adjective 'apparent'.

Incidentally, Mr Sendak's table gives $\alpha^2 = 24 \cdot 42$ although this does not change the value of p which is still at the $0 \cdot 1$ per cent level with two degrees of freedom.

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REFERENCE

Sendak, J. R. (1973). *Journal of the Royal College of General Practitioners*, **23**, 910.

CLASSIFYING DISEASE

Sir,

As a taxonomer by training, and an obsessive-compulsive by personality, I cannot forbear to comment on the stimulating article by Bain, Bassett and Haines in the July *Journal.*

Their emphasis on validity in classification is well placed—they are correct to discuss both reliability (which they show can be checked readily) and validity proper, a most fundamental problem in the young science of family medicine. However, the errors which they point out, seem to rest primarily with the training of their coders. In their table I checked the 29 diagnoses which had caused problems in classification. Of these, 19 could be easily classified by a trained record librarian who looked for the key-word in Volume II of the *International Classification of Disease* (eighth Revision). In most cases, this alphabetical index contained the exact turn-of-phrase used by the recording doctor.

Next, I checked the remaining diagnoses against a classification recently developed to overcome the very problems which the authors discuss. This classification, an updated and internationally agreed development from the Royal College of General Practitioners classification, goes by the mellifluous title of *The International Classification of Health Problems in Primary Care* (I.C.H.P.P.C.). It has been devised by a working party of the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (known familiarly as W.O.N.C.A.). It seems incredible that an international group, which clearly had such difficulty agreeing on simple titles could agree on a 407 rubric classification, but it did! It is now undergoing world-wide field trials—a reliability check, just as the doctors ordered. Three of the remaining diagnoses were covered word-for-word in the English-language version of I.C.H.P.P.C. Two diagnoses ("introspection", "normal development") were not problems any more than "breathing" or "heart beating", but would be easily accommodated in Section XVIII of I.C.H.P.P.C. Presumably, the *problems* were "? abnormally introspective", and "? abnormal development".

This leaves four diagnoses (our of 49, not 50, as stated) which I would expect a trained record librarian to check with the doctor. If I understand the paper correctly, a rate of 16 checks per year for three recorders is not at all onerous. Furthermore, McFarlane and Norman (1973) have shown that time *is* on their side—after 20 months the record librarians become familiar with the terms used by their doctors. I should point out that one advantage of a short-list is that it is compact enough for the general practitioner to become familiar with its orientation and philosophy, even if he is lucky enough to employ coders.

To their comment "The solution to the problem is not one of devising new systems of classification, but of improving the *I.C.D.*", I add a fervent "Amen". I know I.C.H.P.P.C. is not perfect—no classification is—but it will carry the force of world opinion in general practice. I believe that it will provide an entrance to the deliberations of the Classification Committee of the W.H.O., and the Nosology Group in C.I.O.M.S. (Council for International Organisations of Medical Sciences). Other international organisations for various specialties already make recommendations to these important bodies. In North America, the Society of Teachers of Family Medicine has already participated in the first revision of (H) I.C.D.A., the classification most used for coding hospital diagnoses, and one which exerts considerable influence on the development of *I.C.D.*

I hope I can continue in this correspondence with your enlightened contributors from Livingstone New Town, but outside the pages of your busy *Journal.*

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REFERENCES

Bain, D. J. G., Bassett, W. J. & Haines, A. J. (1973). *Journal of the Royal College of General Practitioners*, **23**, 474–479.

McFarlane, A. H. & Norman, G. R. (1973). *Medical Care*, **11**, 101–108.