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 0·1 per cent level with two degrees of freedom.

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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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