staff of a hospital has great advantages because the hospital is the very centre and spring of all medical knowledge." Mr Honigsbaum underlines this frequently by referring to what he calls the "social work concept of general practice" which seems to exclude the care of organic disease.

It is striking how few references there are to any achievements of general practice or general practitioners. He does refer briefly to Sir James Mackenzie but makes the error (p. 95) of stating that he "failed to obtain a place in a hospital", whereas Mair (1973) has shown that he became the "Physician in Charge of the Department for Cardiac Research" at the London Hospital (p. 258).

How would Mr Honigsbaum handle the educational and research developments in post-war British general practice?

In fact, he solves these issues simply by ignoring them. The list of acknowledgements includes none of the leaders of the Royal College of General Practitioners, and the College and all its publications get a handful of mentions in 300 pages, against a chapter for the antivivisectionists and liberal quotations from the Socialist Medical Association and Lord Moran.

Mr Honigsbaum appropriately closes his work with a quotation from Lord Moran which neatly fits his theme: ". . . that in time the pick of the general practitioners must follow their patients into hospital and will become part of the staffs of those hospitals. I know it will be said that the standard of those hospitals will go down, but I do not think that that should happen if we see that the general practitioners are properly integrated with the consultants already on the staff of the hospitals."

The whole mammoth work is rather sad. Mr Honigsbaum has two *idées fixées,* first a preoccupation with the policies of the socialist groups which, while interesting, are not in the end of overriding importance, and secondly his certainty that the hospital is the centre point of medicine. In ending with the statement that general practitioners have been denied access to "the main centre of professional work" he dismisses without discussion the concept of a personal, accessible, home-based medical service, which can include the care of the majority of patients with asthma, coronary thrombosis, diabetes, duodenal ulcer, pneumonia and offer personal preventive care as well. Furthermore, the total cost of British general practice is very low and it is producing results comparable with other nations at substantially lower cost. Mr Honingsbaum has not just missed the bus—he had not yet found the bus queue!

Primary medical care will always be under pressure to become more like secondary or hospital care, and there will always be those who want the hospitals to absorb or take it over completely. However, general practice is actively resisting this pressure and is orientating itself firmly towards the needs of patients in their local communities.

It is a pity that the division in British medicine, which is real enough, is seen only in terms of general practice's failure and separation from the hospital service—rather than in terms of the success of general practice in keeping close to the needs of its clients.

D. J. PEREIRA GRAY

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ICHPPC-2 (INTERNATIONAL CLASSIFICATION OF HEALTH PROBLEMS IN PRIMARY CARE) 2ND EDITION

Prepared by the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA).

Oxford Medical Publications Oxford (1979)

146 pages. Price £8.50

The urge to phoneticize a set of initials is almost irresistible and when this is done to the International Classification of Health Problems in Primary Care the result is 'Itchpick', an inelegant description of an extremely elegant classification which should always be honoured with its full title, or abbreviated to ICHPPC.

The taxonomy of phenomena observed in general practice began with the Records and Statistics Unit of the College, and after an attempt at a hierarchical classification which nobody could be persuaded to use, a short-list of the International Classification was decided upon. This underwent further changes to make it more effective for its purpose—the study of various aspects of practice in the United Kingdom.

In 1972, the Conference of the World Organization of National Colleges and Academies of General Practice (WONCA—acronyms seem inescapable) realized that this classification could be the basis of a truly international system which could be strictly related to the *International Classification of Diseases (ICD).* A working party was set up, and how that party worked!

It is unusual for international affairs to go smoothly but representatives of 14 countries made common ground and field-tested a short-list of the ICD. The working party became the Classification Committee of WONCA and was able to introduce ICHPPC-1 in Mexico City in 1974.

The present volume comprises ICHPPC-2, further evolutionary improvements made necessary by changes in the ICD itself. The Classification will be reviewed and brought up to date with every future revision of the ICD.

It must not be thought that the WONCA team is resting on its laurels, for it is working hard on definitions which can be applied to the rubrics in ICHPPC, and so make this the most specific and precise instrument of its kind that has ever been devised.

Many research workers in the UK will have accustomed themselves to using the ICHPPC in parallel with the College Classification, which it will ultimately replace. Those unfamiliar with the research work of the College may also take some pride in the development which its offspring has undergone.

R. J. F. H. PINSENT

NAMES WE REMEMBER. 56 EPONYMOUS MEDICAL BIOGRAPHIES

C. Allan Birch

Ravenswood Publications England (1979)

165 plus xi pages. Price £9.75

There are few doctors who have not wondered from time to time about the great ones who have left their names on the signposts of medicine. What sort of a fellow, for instance, was the up-turned Babinski, or Huntington, or the triangular Scarpa? Dr Birch has answered 56 of these questions in his collection of eponymous biographies.

Of necessity the treatment is synoptic, and none the worse for that, for the reader will find a short bibliography to start him on the track of any eponym in which he is especially interested.

It is odd how some of them are immortalized for the wrong reasons. For instance, that great and good man, John Ryle—for whom as students we had respect only just this side of idolatry—is

remembered not for his classic *Natural History of Disease,* but for a ridiculous little piece of rubber, suggested incidently by his wife, who understandably had tired somewhat of his weekend hobby of trying to stuff a great metal-tipped Einhorn tube down her oesophagus to study the gastric juices.

In the small compass at his command the author manages to give many little anecdotes of this kind, which make for light and easy reading. Each subject has his portrait and a succinct description of his syndrome or whatever.

This is a delightful little book, researched with care and compressed with great skill, but where are the ladies? Fifty-six eponyms—and all male. That will never do. Here is a chance for somebody.

J. R. MILES

REPORTS

Annual Symposium of the Royal College of General Practitioners

THE Annual Symposium of the Royal College of General Practitioners was held at the Royal Geographical Society, London, on Friday, 15 November 1979.

The theme was "Looking After Children" and had been chosen by the College to mark the International Year of the Child. The Chairman was Dr Denis Pereira Gray, General Practitioner, Exeter, and the meeting was attended by about 250 people.

Dr Graham Curtis Jenkins

Dr Graham Curtis Jenkins, General Practitioner, Ashford, opened with a paper entitled "What are we trying to achieve?". He suggested that the corner-stones of paediatric preventive medicine were: 1. Immunization; 2. Nutrition; 3. Health education; and 4. Treatment.

Dealing with immunization first, he pointed out that in the latest epidemic a figure of 90,000 children with notified pertussis, a five per cent admission rate, and 25 deaths, plus a lot of near misses, were a significant reminder of the failure of general practitioners to sell immunization successfully.

Turning to nutrition, he suggested that although breast feeding rates are increasing, in some deprived areas only five per cent of babies are breast fed beyond six weeks, even though breast feeding protects against lower respiratory infections and is virtually unknown in those children who suffer cot deaths.

In dealing with health education, he gave the teething myth, the winding myth, and the belief that picking up babies who are crying will spoil them as examples of misguided information about babies and their care which represented our failure as doctors to alter the beliefs of our patients.

He went on to argue that treatment should include the early detection of handicap, yet 50 per cent of children stopped coming to surveillance clinics after the age of one year, in spite of the fact that 10 per cent of children each year develop new and potentially serious disorders that can lead to handicap.

He went on to ask: "Where are we doctors going wrong?" and argued that first, we are failing to be aware that problems exist, and secondly, we are deluding ourselves that every general practitioner suitably trained can correct the situation.

Developing this theme, he advocated that we cannot wait to train all doctors, as more and more parents bypass general practitioners on their way to care, and he quoted as examples the direct admission of patients with asthma and the open door casualty departments.

Acknowledging the failures of the primary care services, he felt that change must occur as follows:

1. We must meet the challenge of prevention. Dr Curtis Jenkins suggested that this was the first priority, pointing out that information from other countries was relevant to our own.

2. We must accept the need for substantial and continuing re-education, giving up the illusion of curative medicine.

3. We must co-operate closely with those working on other parts of the child health services already involved in prevention, otherwise we will be bypassed in child care.

In summing up he suggested that we have to change our attitudes:

1. By giving back to parents their autonomy, removed by the giving of unnecessary prescriptions.

2. By giving up our exaggerated ideas about the power of curative medicine.

3. By admitting our failures and starting afresh.

Dr James Carne

Dr James Carne, General Practitioner, London, gave the second paper and his title was: "Meeting the challenge of the sick child." He concentrated on the help that could be given by the general practitioner to the child and his parents by a greater understanding of the parent/child relationship.

By treating the child as a person in his own right, rather than concentrating on the symptoms presented by