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New RCGP Classification

Sir,

While Dr Patterson (July *Journal*) criticizes the behaviour of College towards WONCA and regrets the incompatibility of the new College classification with ICHPPC-2, our reservations are more fundamental.

Classification aims 'to order phenomena into groups on the basis of their similarities or relationships'.[1] Unfortunately the phenomena of medicine (perhaps especially of general practice) are capable of classification in a number of ways. First, we must decide what is the *purpose* of a classification. Is it to label, count, compare, predict or a combination of these?[2] The Occasional Paper[3] is not specific on this point. However, much is made (and repeated in Dr Kay's reply to Dr Patterson) of compatibility with ICD-9 and with the needs of the NHS: 'General practitioners in Britain will be capable of providing a unique range of comprehensive morbidity data relating to the population, which will greatly enhance the planning of patient care throughout the National Health Service.' Labelling and counting rather than comparison and prediction seem to be the major purposes of the classification.

It claims to be 'the first classification ... specially designed for use on the computer'. This would be admirable given recognition by the authors that the major requirements of such a classification for the working practitioner are that it is sensitive (as well as specific) and employs labels that are predictive.

At the level of the practice (rather than national surveys) computerized 'morbidity' recording offers the opportunity to follow the symptoms and social situations of individuals over time; to derive a vocabulary of labels meaningful in terms of prediction and thus useful in clinical care.

Currently it is widely accepted that general practice is 'at a loss for words'.[4] Finding the right words will not come about through borrowing the language of specialist clinicians and epidemiologists, as represented by ICD-9; such convergent thinking has led to the adoption for this 'new' classification of categories of social problem rather than social variable and of mental disorder rather than psychological variable. Incidentally, this approach leads to the apparently bizarre conclusion that at least four heads of academic departments of general practice in Britain are suffering from a mental disorder (1125. Smoker, Pipe); presumably most of the remainder are afflicted with 1120. (Non-smoker).

ALISTAIR CAMERON
IAN STANLEY

Division of General Practice
Clinical Sciences Building
St James's Hospital
Leeds LS9 7TF

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Sir,

I read with interest the article 'Where does the College stand in the field of classification?' (Patterson W.M. July 1984) and Dr Clifford Kay's reply as Chairman of the College Information Technology Working Party.

I am a participant in the Department of Industry scheme for evaluation of computers in General Practice. This scheme is organized in 'clusters' of practices so that information and experience can be exchanged, and will involve approximately 500 practices. I have a level two system which is suitable for use in medium-sized practices.

In 1983 I wrote to the RCGP requesting help in setting up a disease indicator computer section and was sent 'RCGP and Office of Population Censuses and Surveys: A classification of morbidity for the national morbidity survey 1970-71', and this has proved an easy system to use in relation to categorizing indicators of disease and recall (for example cervical smears) and thus far the transfer from existing 'problem-orientated' records is proceeding smoothly. It is a system classified simply under 18 headings and appropriately coded. I am now informed that the Manchester Research Unit of the RCGP has produced a classification likely to be used as the national standard. A request for a copy of the relevant publication (Occasional Paper 26) resulted in receipt of an invoice, in advance, for £4.75 even though I am a current member of the College.

Did the Manchester Research Unit consult any practice using computers? Do they know the number of manhours needed to program in the data for several thousand patients? Did they co-ordinate in any way with the only existing major national scheme to evaluate the use of computers in general practice? If they did,

then I find it difficult to understand why the large group including several practices active in College affairs and geographically within their same area were not approached. It would appear that the co-ordination of activities and information in this most important future area is non-existent, as consulting the College secretariat resulted in the provision of existing material which I may add appears entirely adequate.

I expect the College to be able to perform a central co-ordination and guidance forum for the future of general practice. Increasingly it is accused of being remote from its Members and for the activities of its senior Fellows to be largely irrelevant to the needs of mainstream general practice. In this instance the charges would seem fully substantiated.

ADRIAN HART

250 Langworthy Road, Medical Centre,
Salford M6 5WW

Editor's Note: The College classification is *not* free to College Members.

Case finding in preventive care of the elderly

Sir,

We read with interest the Editorial on 'Care in the community' in the July issue of the *Journal* and in view of the present interest shown in case finding as a technique for identifying easily those elderly in the community most in need of general practitioner services, we wish to report the result of a pilot study using this technique.

In December 1983 the computerized age/sex register of a large practice of 11,000 patients close to the centre of Leeds was 'cleaned' for all those patients aged between 74 and 79 years. The medical records were quickly checked to identify any recent deaths, admissions to long-stay care or change of address. This left 354 names. In January 1984 these patients were sent Barber's postal questionnaire of nine screening questions requiring a Yes/No answer.[1] A stamped addressed envelope was enclosed inviting participation in the survey and signed by the senior partner in the practice. Within one month of mailing 330 questionnaires were returned, of which 323 were completed. A second mailing of the 24 non-respondents produced a further 12 completed questionnaires. Overall, 335 questionnaires were returned completed (95 per cent). Not only was the response rate high but a number of the old people added comments of praise for the idea and amplified answers to some questions. Analysis of the questions revealed only 20 per cent where there was no 'Yes' answer. On Barber's criteria, therefore, 80 per cent of the respondents were in need of further assessment. This is almost identical to Barber's findings but seemed high if the technique is to be used regularly. The money spent on mailing the questionnaires may as well have been spent on visiting the remaining 20 per cent. Moreover, follow-up of some of the elderly (7 per cent), revealed that comprehension of the questions had not always been complete.

We feel that although the technique has proved a successful method of contacting the elderly in the practice, the questions themselves were not sensitive enough to select the elderly most at risk. Work is now taking place on devising and testing a more discriminating initial screening instrument as a prelude to a double-blind two year trial using this technique.

A.W. CAMERON
J.M. WRIGHT

Meanwood Health Centre
548 Meanwood Road
Leeds LS6 4JN

Reference

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Night calls - an emotional editorial

Sir,

The author of your unsigned editorial on night calls was wise to remain anonymous. But, in allowing him to do so you must then assume responsibility for what he has written.

Since most of his opinions cannot be substantiated, not only is the editorial unhelpful but it also casts doubt upon the College's ability to produce the facts which are necessary to support its arguments about the provision of out of hours work.

At least a previous editorial on the subject[1] admitted that facts were necessary to justify the College's policy. If it is felt that this is no longer so (and as far as I am aware they have never been produced) then the College must come clean and admit that its interest in the out of hours debate has shifted from being academic to being political.

As Robert Thouless has said, 'Effective democracy requires that people shall make decisions by a process of calm appraisal of the facts. Such calm appraisal is obstructed by the use of emotional oratory in presentation of the facts.'[2]

J.S.K. STEVENSON
Senior Lecturer

University of Edinburgh
Department of General Practice
Levinson House, 20 West Richmond Street
Edinburgh EH8 9DX.

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