derstand it and share it in terms that make sense to the patient, which may help him to change.

Doctors in a Balint group are constantly examining what happens to patients over a period of time and trying to assess and evaluate what part the doctor has played in any changes that occur.

There will be a Balint Memorial Lecture on Tuesday, 24 January 1978 at 20.30 hours at the Royal Society of Medicine, given by Dr Tom Main, on the subject, "Some Medical Defences Against Involvement with Patients". A loaded title? Of course it is, but it implies that all of us are in doubt over what good doctoring should be. Dr Main has spent many years listening to doctors debating this.

I should also be pleased to provide further details of the Balint International Conference to be held at Imperial College, London from 8 to 10 September 1978 on the topic "Aims Achievement and Assessment of Balint Training".

CYRIL GILL
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Sir,
I much enjoyed and sympathized with Peter Sowerby's excellent and timely article (October *Journal,* p.583) on Balintry and science, but I think he rather overdoes his claim that Popper was a revolutionary innovator in the theory of science. I quote the following from Bertolt Brecht's play, *The Life of Galileo,* completed in 1947, more than a decade before Popper's view became current: "One of the chief causes of poverty in science is imaginary wealth. The aim of science is not to open a door to infinite wisdom, but to set a limit to infinite error . . . My intention is not to prove that hitherto I have been right; but to discover whether I am right. I say: abandon all hope, you who enter the realm of observation. Perhaps they (sunspots) are clouds, perhaps they are spots, but before we assume that they are spots, which would be most opportune for us, let us rather assume that they are fishes' tails. Yes, we will question everything, everything once again. And we shall advance not in seven-league boots, but at a snail's pace. And what we find today we shall strike out from the record tomorrow, and only write it in again when we have once more discovered it. And what we wish to find, if we do find it, we shall regard with especial distrust."

Whether such clarity was achieved by Galileo himself, or later by Brecht through his contact with the physicists preparing the end of the world in California in 1944, I am not scholar enough to know; but to me, Brecht the artist was in all senses more revolutionary than Karl Popper the scientist, not only in art but in the ideology of science. Later in the play, faced by the inquisitors, Galileo recants and in his broken old age confesses to posterity the blight he has cast on science by allowing it to become a tool of the gentry: "As things now stand, the best one can hope for is for a race of inventive dwarfs who can be hired for anything."

"A terrible unrest has come into the world," admits the inquisitor. "It is this unrest in their own minds which these men would impose on the motionless earth. They cry: the figures compel us! But whence come their figures? They come from doubt, as everyone knows. These men doubt everything. Are we to establish human society on doubt and no longer on faith?"

Balint had enough faith in man to have doubts about the established beliefs of his time and was in this sense a great scientist. His discoveries contained errors, magnified by less imaginative disciples and imitators, to the point where Dr Sowerby's article is long overdue. However, I shall persist in an unrepentant confusion of art and science in the grand old cause of returning both to the people.

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Sir,
I enjoyed Dr Sowerby's article (October *Journal,* p.583) and its well documented criticism and I would like to make some observations.

There appears to be a danger in dividing the medical approach into a scientific one and (for lack of a better description) a psychotherapeutic one. It is difficult to take a person apart and look at his organic illness separately from his emotional involvement; it is the whole personality which should be considered and understood.

When it comes to treatment, there are methods of approach which are acceptable if they relieve the patient of his painful symptoms or even cure his 'dis-ease'. The method depends on the doctor's training and his experience, seldom on scientific papers. Depression, which Dr Sowerby often mentions as a diagnosis, can be treated by ECT, by drugs, or by psychotherapy. Apart from 'endogenous' depression, which is best treated by ECT or drugs, I have found it difficult to diagnose depression. Depression due to what? If we can discover the reasons for depression, we might not be scientific in our treatment, but we will not need ECT or drugs.

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THE INDEPENDENCE OF THE PROFESSION

Sir,
In a recent letter published in the *British Medical Journal* (Grüneberg, 1977) concerning the Proposals for Regulations, NHS (Vocational Training) Act 1976, I drew attention to two matters of major principle which may be of interest to your readers. They represent my personal view.

1. It has been generally accepted that the essence of a profession is that it is self-regulating. For the medical profession this has meant that for most specialties the requirements for specialist training have been decided by the Royal Colleges. It is now proposed that the requirements for specialist training in general practice should be decided by the Department of Health and Social Security, albeit with the advice of the Royal College of General Practitioners and the General Medical Services Committee. It is conceivable that at some time in the future the Department might dispense with this professional advice. However, I submit that the proper authority in this matter is not the DHSS and that the acceptance by the Royal College of General Practitioners of a merely advisory role may in the long-term destroy the College.

Similar regulations could at some future time be laid down by the Department in relation to other specialties. The Royal Colleges may wish to consider where the interests of the profession lie.

Further, should the Royal Colleges wish to surrender their traditional role as regulators of postgraduate training requirements, I question the desirability of this being taken on by the Department. The DHSS has a strong commitment to staffing the Health Service. This might at some stage be in conflict with the maintenance of satisfactory standards in postgraduate training.

2. The Proposals for Regulations for specialist training in general practice enshrine a new principle (Clause 6), namely, that experience gained is of no value after the lapse of a period of time. This is a principle which has not been ac-

cepted in other specialties. It should not be introduced without wide consideration of its potential effect on the careers of men and women doctors. It appears likely that dangerous precedents could be set by the mechanism of regulations such as these.

It may be that by the time this letter is published Clause 6 will have been deleted from the Regulations. Even so, it will be worth noting as a signpost marking a route which I think is inappropriate for the medical profession to take.

There is a danger that the DHSS will continue to try and control vocational training for general practice. It is stated in the Proposals (Clause 4) that the DHSS will follow up the question of educational approval for the hospital content of vocational training. There is also the suggestion (Clause 11) that there will be an Appeal Body containing a representative of the DHSS.

I have had the honour to receive letters from the President of the Royal College of General Practitioners and the Chairman of the Council of the British Medical Association in reply to my letter in the *British Medical Journal*. However, these did not specifically answer the points raised and I should therefore be grateful if you would allow me to make them known through your *Journal* in the hope that they may receive appropriate attention.

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Reference

Grüneberg, A. (1977). *British Medical Journal*, **2**, 1030.

CODING MORBIDITY

Sir,
We are often perplexed by records received from a previous doctor, which contain cryptic comments like 'CNS' or 'CVS, NAD'. The problem is that we have no means of knowing what particular examinations have been undertaken.

It would be helpful if a simple coding system could be devised so that, for example, CVS 1, NAD meant that certain specific pieces of examination had been completed. The coding should at its first level indicate standard, if minimal, procedures, with lower levels in each case indicating the completion of 1 and/or 2 and consisting of specific pieces of examination required less often.

The coding should relate to such examinations as the general practitioner considers to be appropriate and refer only to procedures which he might be expected to conduct in his own consulting room, or even the patient's home.

Any items requiring the referral of the patient or specimens to any outside agency would normally be reported and recorded separately. Thus the use of 'Labstix' or a peak-flow meter would come within the code; a mid-stream urine specimen or a chest x-ray would not. Many general practitioners now have and use ECG machines, in which case an ECG record could be contained within the code.

It is important to appreciate that the purpose of the code is to clarify the specific items of observed normality. Any abnormalities are recorded. Thus, "CVS 1, BP 180/110" would indicate that only the blood pressure was abnormal in the specified set of procedures indicated by that code. It is useful to record the blood pressure among other items as part of "base-line data".

Bearing in mind the ground rules, I have worked out a code (Table 1). It is hardly likely that it will meet with universal approval or use, but it might be a basis for developing a simple useful clinical tool.

The examples given in the table are only possible items, and are but a restricted list. The items do not, nor are they intended to, include all possible examinations. Nor is it suggested that CVS 1, for example, be undertaken in entirety. The extent of the examination of any patient at any time is the decision of the general practitioner in question. Should he decide merely to auscultate the heart, then let him either record "heart sounds normal" or describe the abnormality. This applies to the use of any items of examination which do not add up to a complete code 'package'.

However, the items suggested in the

Table 1. A simple coding system.

Code	Consists of:
CVS 1	Inspection, palpation, percussion and auscultation of precordium Blood pressure (sitting or standing) Radial pulse JVP
CVS 2	1 + Femoral and tibial pulses Exercise tolerance test ECG (if done in general practitioner's premises by or on his behalf)
RS 1	Inspection, palpation, percussion and auscultation of chest (which was fully exposed)
RS 2	1 + Examination of nose, throat, and sinuses Peak-flow meter result
RS 3	2 + Laryngoscopy
GU 1 (Female)	Palpation of abdomen and kidneys 'Labstix'
GU 2 (Female)	1 + PV and bimanual
GU 1 (Male)	Palpation of abdomen and kidneys Observation and palpation of cords, testicles, and penis 'Labstix'
CNS 1	Gait, biceps, abdominal, knee, ankle, and plantar reflexes Rombergism, arm and leg strengths Tremors
CNS 2	1 + Cranial nerves Finger nose test
CNS 3	2 + Full 'pin-prick', cotton wool, and tuning fork tests