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.

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

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

code represent commonly used 'packages' of examinations which, if undertaken, can conveniently be recorded by the code. At any time, examinations infrequently used can be recorded individually.

Some practices, I am sure, already have their own coding system. Perhaps the College might develop a system for potential national use?

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EDUCATION AND TRAINING OF DISTRICT NURSES

Sir,

In November 1976 the Panel of Assessors published their *Report on the Education and Training of District Nurses (SRN/RGN)*. The report, with a summary of the comments received from health authorities and other organizations, is under consideration by the Health Departments.

One of the recommendations was that there was a need for a working party to be established to consider the education and training of the enrolled district nurse. This has been accepted by the Health Departments and the panel have now set up a working party to advise them within the following terms of reference: "To devise an improved syllabus or curriculum for the district training of the enrolled nurse without prejudice to the implementation of the Briggs Report on Nursing".

The working party would be pleased to receive comments from readers on the role and training of the enrolled district nurse. They should bear in mind the recommended curriculums for the registered nurse. Comments should be sent in writing to me at the address below as soon as possible.

T. W. MATTHEWS
Secretary
Panel of Assessors for District Nurse Training

Hannibal House
Elephant and Castle
London SE1 6TE.

BOOK REVIEWS

TRENDS IN GENERAL PRACTICE 1977

Royal College of General Practitioners
J. Fry (ed.)

British Medical Journal
London (1977)
193 pages. Price £4.50

A sense of history is as important to medicine as it is to politics and this book would be worth buying and reading for its first chapter alone. This is a brief historical review, written by Dr Loudon, of the relationship between general and hospital practice; and its importance lies simply in the fact that the so much needed clinical reunification of the profession is unlikely to be achieved until the historical roots of present divisions are understood.

The book itself is a descendant of previous *Reports from General Practice* published by the *Journal* in 1965, 1970, and 1973, under the title of *Present State and Future Needs of General Practice.* These were written by Dr Fry who edits and contributes to the present volume. The aim of the book is "to describe developments up to the present date and to propound the views of the authors on their significance."

Altogether, 11 authors contribute. After Dr Loudon's historical review, Dr Fry writes on "The Place of Primary Care", and Dr Howie on "Patterns of Work". These are followed by six contributions from different authors on various aspects of practice: "The content of Practice", "Child care", "The Elderly", "Obstetrics", "Fertility and Family Medicine", and "Induced Abortion". Later chapters are devoted to organizational issues ("The Practitioner and the Hospital", "The Health Team", "Premises and Organization"). Finally, there are chapters on "Prescribing" and "Education for General Practice", followed by an epilogue on "Future Needs".

After reading many of the chapters, the reader may well feel that the book would have been better entitled 'Trends in the Background to General Practice', since it provides much more factual information about demographic and social changes that have (or should have) a direct impact on general practice than about adaptive changes in practice itself. In this respect, Dr McEwan's contribution on "Fertility and Family Medicine" and Dr Frank's review of "Induced Abortion" are outstanding—both clearly highlighting the complex social trends which general practice must face.

Inevitably and valuably the approach of the authors to their allotted subjects varies widely. For example, Dr Howie's contribution on "Patterns of Work" is a scholarly comprehensive review of 50 original papers, while Dr Lloyd's section on "Obstetrics" ingeniously juxtaposes statistical material on recent trends in the maternity services. However, the material also varies in standard —and of two sections dealing with subjects of considerable clinical importance, one is frankly inadequate, and the other confused and partisan.

Perhaps, however, the book's most serious defect is its failure (with some honourable exceptions) to crystallize the adaptative changes which demographic and social trends demand of general practice. These could valuably have been highlighted at the end of each chapter. It is unfortunate that the book finishes with a platitudinous epilogue—particularly when the question is currently being asked: "Is the general practitioner—compared with other alternative forms of primary medical care—worth his salt?"

Nevertheless, this is a book worth buying and reading by trainees and principals alike. The reader may be irritated by the too numerous typographical errors, but there is plenty of useful material between its covers.

H. J. WRIGHT