Audio-visual recording in the surgery

Sir,
The survey by Dr I. K. Campbell of the reaction to his patients in King's Lynn to the experience of being video-taped (September *Journal* p. 548) interested me as I had recently completed a similar investigation. I suspect that there are many social differences between patients in King's Lynn and in Liverpool. Despite this my findings, using a sample of 100 patients and a similar questionnaire, were exactly the same as those of Dr Campbell.

2 per cent of those asked did not wish their consultation to be recorded. 6 per cent of those who agreed to be video-taped would have preferred a second doctor to sit in instead. All the patients, including this 6 per cent, would be perfectly happy to repeat the experience and did not feel the camera inhibited them in any way. Only 10 per cent were even aware of the camera's presence during the consultation despite having had an explanatory leaflet to read beforehand. The technique is clearly acceptable to our patients. The only worry I have is that there may come a time when patients whose consultations are not recorded on film may start to feel that they are being short-changed!

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Is this a Cupping Cup?

Sir,
I picked up this small silver cup (actual measurements 5.4 cm outside top diameter by 4.7 cm high) a few years ago. It is not hallmarked. As an amateur silversmith capable of making such objects, I am satisfied that it is hand made and not intended as a drinking vessel.

I strongly suspect that it is a 'cupping' cup, but I have failed to find any other silver cupping cups with which to compare it. I have taken it to the Wellcome Museum and the Museum of London but, although their cupping cups (in glass) are almost the same in size, shape and design, they cannot find any reference to silver cups of this type. Perhaps our more senior members may have knowledge.

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We sent the photograph to Dr Peter Thomas, the Honorary Curator of the College Museum, who sends us the following note:

The object is very much like (almost identical with) what Dr Grant suggests it is—a silver cup for cupping purposes. I have searched through three nineteenth-century instrument catalogues, the earliest one being Maw & Son (1866), but the cups in these works are all made of glass. The ancient Graeco-Romans usually used ones made of copper, which show a beautiful jade green patina after long burial in the earth. Is Dr Grant satisfied that the cup is made of silver? Could it be just a drinking vessel, a landlord's drinking measure or a communion cup; or is it a galley-pot for holding a doctor's healing medicaments? Pewter instruments were popular from the seventeenth century onwards.

The Care of Patients Dying from Cancer

Sir,
Dr Woodbine's survey (November *Journal,* p. 685) shows many of the problems encountered by doctors both in hospital and in general practice, when caring for patients dying from cancer.

I would disagree with him when he states that "many symptoms, for example weakness or loss of weight, cannot be controlled at the present time". Many symptoms can be helped and loss of appetite, and in some cases weakness, the two commonest symptoms in the survey, may be helped by glucocorticosteroids (such as dexamethasone 2 to 4 mg a day), although there have been no controlled trials confirming this. A survey of the 53 patients in St Christopher's Hospice on 24 November 1982 showed that 29 patients were receiving corticosteroids. For 12 patients the drugs were prescribed to increase the feeling of well-being and to aid appetite, and in nine of these patients there had been a good effect.

Corticosteroids can be very helpful in improving appetite, increasing the feeling of well-being and reducing the feeling of weakness in patients with far advanced cancer. Although pain is a very serious symptom, other symptoms can also cause much distress and they too must be fully assessed and treated.

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How are the University Departments Faring?

Sir,
Your editorial on academic general practice (October *Journal,* p.587) appeared on the anniversary of my resigning from the academic department of general practice at a London teaching hospital, so perhaps I might be allowed a few comments.

Historically, academic departments were introduced to medical schools in order to further subjects and they have invariably succeeded where they have been introduced. They have three functions: to research, to teach and to perform. The problem in all present academic departments of general practice is that the service commitment overwhelms the first two.

You state correctly that these departments should be welcomed by universities, the DHSS and local general practitioners. In my experience this is far from so. To introduce any new department into a medical school must mean that other departments lose both curriculum time and part of their share of resources, so no new department is welcomed with open arms. Principals in general practice are either indifferent or, if an academic department is planned to start in their area, often hostile. The reasons for this can be inferred, but no-one has yet informed me directly why this is so.

The DHSS is financially supportive and I believe some money may be forthcoming in the near future. But no political move in the area has ever been made.

However, the main culprit in my view is the College. The College was instrumental in starting postgraduate training and has now handed over half of its baby to the JCPT. However, postgraduate training should be a continuum from undergraduate training and thus *not* separated from university de-