reminder to all members of the practice team and serves as a useful start to introducing the idea of practising prevention. Its use can be extended by including details of attendance for developmental checks.

This chart was developed and used at the Cymmer Health Centre, West Glamorgan. I am grateful to the staff there, and particularly to Jean Williams, receptionist.

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Reference

1. Smith T. Our national resistance to immunization. *The Health Services* 1983; **March 11:** 12.

Psychiatry in General Practice

Sir,

In an editorial (April *Journal,* p. 195) Dr Anthony Clare described three possible approaches to improve psychiatric management in primary care. More involvement by psychiatrists at one end and by social workers at the other, and strengthening the general practitioner's own skills.

Valuable as the first two suggestions are, I do not see them as a substitute for improving our own skills.

The actual techniques of interviewing can be improved by role play, video-recording and analysis of the process of consultation, but if we are to progress from his depressing analysis that our major form of treatment is by psychotropic drugs, something more is needed.

Patients come to doctors with emotions that are often intense and wrapped up in ways that are peculiar to the general practice setting, which is often 'gift wrapping' to those doctors who try to see beyond the presenting complaint to what lies beneath it. All this is lost when the patient is referred to someone else. Awareness of the general practitioner's own involvement in the consultation, and how this may reflect the patient's other relationships, are best learnt slowly in a group setting.

As a dedicated member of the Balint Society two things encourage me in the present state of general practice. Vocational training implies half-day release courses, where trainees naturally gather in small groups for case discussion. The problems that they wish to discuss are nearly all concerned with management of emotional and family problems. I hope that many trainees are now learning the value of sharing such problems in a group, and that they will wish to take such learning further when they are established.

The other encouraging thought is that I believe doctors are choosing to go into general practice because they are interested in such psychosocial matters. I hope that this may filter back to influence the selection and training of medical students. When I left hospital for general practice in 1953 I thought that everything that was not hospital-style medicine was nonsense. The present generation of trainees is much more sophisticated.

Dr Clare rightly suggests more intense investigation of the whole problem of psychiatry in general practice. An important part of this would involve assessing how trainees are changed during their training, both by groups and by individual supervision.

Assessing the value of our efforts with patients is even more difficult, since orthodox psychiatric classifications have little bearing on the rich variety of human problems that are brought to us all the time.

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Training in Geriatrics for General Practice

Sir,

A report by the British Geriatric Society and the Royal College of General Practitioners in 1978 on training general practitioners in geriatric medicine[1] suggested that 'all vocational training must provide training in geriatric medicine', yet in 1981 only 26 per cent of schemes approved by the College had a compulsory appointment in geriatrics for three or six months, and only a further 25 per cent had a voluntary appointment available.[2] This position has not changed significantly in the last two years.

This apparent reluctance to include geriatric medicine in vocational training schemes is surprising. The reason for this omission is not clear but perhaps the organizers of vocational training schemes consider that the experience gained in hospital practice is not of direct relevance to the management of the elderly in the community.

Whilst one of us (M. B. J.) was working as a senior house officer in geriatric medicine as part of a general practice vocational training scheme recently, we compared the medical and social problems of a group of 68 patients admitted to the geriatric assessment unit of a district general hospital with a similar group of elderly patients under the care of general practitioners in the same area.

Our results showed that the patients seen in hospital differed from those seen in general practice only in being older and more dependent and were otherwise very similar both medically and socially. This strongly supports the view that experience gained in managing patients whilst under the supervision of a geriatrician and obtaining first-hand experience of the organization of a geriatric service relates directly to the management of elderly patients in the community.

In view of the rapid increase in the elderly population in the country it is of great importance that general practitioners are competent in supervising the care of the elderly. The provision of more hospital geriatric training posts in vocational training schemes would help to ensure this.

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References

1. British Geriatric Society and Royal College of General Practitioners. Some aims for training in general practice. *J R Coll Gen Pract* 1978; **28:** 355-357.
2. Council for Postgraduate Medical Education in England and Wales. Vocational Training Schemes for General Practice. 1981.

An MD from General Practice

Sir,

It is never easy to attempt an MD from general practice, and to be unsuccessful in the end can be shattering. Those of us who act as examiners for the London University degree have been concerned about many of the theses with which we have been presented and hope that the following suggestion will be useful to anyone thinking of becoming a candidate.

In this University there is no supervisor for the work, since it is held that anyone fit for the degree does not require one. Help from appropriate academic quarters is encouraged, but when the adviser is an expert in a specialized field, the help that he or she can offer may be more limited than the candidate really needs. It seems, from a number of recent submissions, that advice is also needed from someone who is familiar with the problems both of general practice and of doctoral research.

Senior members of the departments

of general practice in the various London medical schools have expressed their willingness to help in any way that they can. I would urge any general practitioner considering a London MD who does not feel completely familiar with what is involved to contact one of them, or, failing this, to write to the chairman of the Special Advisory Committee who should be able to suggest a suitable person to approach.

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Silence

Sir,

'Silence is golden', says the proverb, yet when we tape-record consultations the silences we hear are usually just because the doctor is busy with something else. For once there is no proverb on this point of equal and opposite force, and it would seem that the use of silence as a deliberate tool is neglected. Yet silence needs no definition and we have, unusually when looking at human behaviour, a means of measuring it along the yardstick of time. The doctor aware of the limited quantity of his time may see silence as wasted and try to fill it usefully, but a willingness to spend time may itself be an active ingredient. Without words we must look elsewhere to further our understanding of the quality of silence, and non-verbal communications usually give us clues to what is going on.

A working silence, when the patient is preoccupied and looking inwards, suggests that he is thinking about his problems and should be left to do so in the hope that he will find some insight. If in doubt we may check that we are understanding this correctly, and we may ask him what it is about, not so much for our benefit as for his, in that the putting of it into words clarifies the feeling and makes it more accessible.

An awkward silence is when a patient leaks his distress by restlessness of the eyes or body, by flushing or swallowing or by a change of subject. It is our job to help him overcome this difficulty while respecting his urge to cover up again. The blockage may lie between us—the patient is not yet ready to trust his doctor with embarrassing material. Here the impediment can be most effectively overcome by sharing some of ourselves with our patient, which helps him to feel more equal and models what is required. However, the problem may lie inside the patient who is carrying a load of left-over feelings too impacted to share even with himself, much less with the doctor. To clear these, the patient's self-respect must be built up so that he can respond to the doctor's efforts to help him release his pain.

In these ways we hope to achieve the comfortable outward looking silence that indicates our patient has finished, and to encourage those occasions when one says, 'Thank you for listening. I never told anyone that before; it helps'. This induces warm feelings inside us which should remind us that while these processes are seen in our patient equally they occur within us. The preoccupation of thought, the effort needed for an unattractive patient, the hopelessness of some peoples' lives, are warnings to look at ourselves and perhaps even to accept help from our patients.

So silence can be just emptiness, but to make a silence takes two, and to make a silence golden takes more than time.

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Is this a Cupping Cup?

Sir,

I was very interested in Dr R. N. R. Grant's letter and the photograph of his silver cup (February *Journal*, p. 123). By its form it looks like a cupping cup, and by its volume, rather less than an ounce, it is unlikely to be a drinking cup. Perhaps it is a cup for taking liquid medicines.

Why is it not hallmarked? This may prove a clue. When did hallmarking start? Did Roman silversmiths hallmark their wares?

If it is Roman then it is probably a cupping cup belonging to some Roman general with a chronic chest complaint who frequently resorted to cupping, during the invasion of Britain. He had a set made of silver and this is one of them. Why a general? Because a general could afford silver cups. A Roman legionary would not have a chronic chest complaint and he would not drink from a cup this size. He would drink straight from the bottle.

Dr Peter Thomas says Greeks and Romans used cups made of copper. Professor Arturo Castiglioni[1] of Yale University says that Greeks used cups of glass or metal. Silver is metal.

Greeks and Romans did not know distilled liquors so their wines could not be stronger than 15 per cent alcohol (a point at which the fermentation stops) and Greeks even used to dilute their wines with water. Dr Grant's cup will hold less than a tot of whisky and is quite useless for drinking purposes, even of neat whisky, and hopelessly inadequate for wine diluted with water. All the pictures of ancient Rome and Greece show much bigger vessels of adequate capacity and they all had a stem to hold them by.

Why not ask Professor Castiglioni himself? He has a beautiful collection of ancient porcelain pharmaceutical jars for medicines and would probably have heard of or even seen a silver cup.

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Reference

1. Castiglioni A. A History of Medicine, New York: Alfred A Knopf, 1946.

How shall we remember John Stevens?

Sir,

Following Ian Tait's letter (April *Journal*, p. 250) it would be most appropriate to remember John Stevens by commemorating a particular skill that he had which transcends all his others, namely his ability to inspire and encourage medical students and trainees to enter general practice by demonstration of his own skills as a doctor with one-to-one teaching in his own consulting room. The effect of this on those of us fortunate enough to have spent a few days at Aldeburgh was shattering.

I therefore suggest that a travelling bursary be established to enable trainees to select individuals with whom they would like to spend four or five days and to finance their travelling and other expenses. A trainee or medical student who knows of a particular person with whom he or she would like to spend some time could apply for such a bursary.

This would be a more appropriate way of remembering John Stevens than the provision of another essay prize, memorial lecture or medal.

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