the missed pill rule, agreed by the National Association of Family Planning Doctors and the Family Planning Association in 1986 and about many other aspects of pill taking. A submission for an amendment to the data sheets has been made to the Committee on Safety of Medicines.

Until such time as the packet inserts are revised, we should tell patients to read the section on missed pills in the new Family Planning Information Service leaflet. However, I would hope that we would continue to hand out the FPIS leaflets to every patient prescribed the pill, as the new versions incorporate the valuable findings of consumer research specially commissioned at the University of Strathclyde advertising research unit.3

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References

Sir,
Dr Metson has drawn attention to the lack of uniformity in the advice given by the Family Planning Information Service (FPIS) in its most recent leaflet and the data sheets of the manufacturers of oral contraceptives (Letters, May Journal, p.226). Dr Metson generously does not attempt to blame anyone for this unsatisfactory situation. Nevertheless, I should like to add one or two comments from the point of view of a consumer of the pill.

It should be realized that when the pill was first introduced, many of the questions asked about its optimal use could not be answered, and, owing to its remarkable efficacy, questions about the effects that variations in use would have on efficacy could not be answered by direct experiment but have had to rely on indirect evidence, such as studies of cervical mucus, hormone assays and, in the last two or three years, ultrasound scanning. Twenty-eight years after the introduction of the pill, most people in this country are still unaware that starting the pill on the first day of menstruation without additional precautions, and wanted the manufacturers to follow suit. At a meeting of the FPA's medical advisory committee, the manufacturers and a representative of the Committee on Safety of Medicine's secretariat, the latter refused to allow the manufacturers to adopt the recommendation that the FPA was already making, or, to be more exact, refused to allow the extrapolation of a principle that had already been shown to work in clinical trials of a low-dose pill to older and higher-dose pills. Ten years later, the discrepancy still exists as far as the older pills are concerned. It is unfortunate that the FPIS leaflet has introduced further confusion as a result of unilateral action before the manufacturers had been consulted. The manufacturers had already shown their ability to reach a consensus in 1977 when they produced a uniform text for the much fuller leaflets for patients that were soon to be produced. It is true that minor differences exist between the data sheets, but they do not reflect differences of any real substance.

Fortunately, relations between the FPA, the National Association of Family Planning Doctors and the manufacturers have become closer in the last two years, and a joint working party has drawn up a new provisional text, which will be considered by all of the manufacturers individually, but there are not likely to be any serious obstacles to its acceptance. The text contains the so-called 'seven-day rule' and a recommendation to start the first course on the first day of menstruation. The FPIS is free to say what it likes, but the manufacturers must wait to see whether or not the DHSS will accept the arguments in favour of these two recommendations and allow the manufacturers to incorporate them into their literature.

There will always be points of disagreement on medical matters, but I ask Dr Metson, and others to understand that it is not for want of any cooperation by the manufacturers that these discrepancies exist.

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Understanding Latin abbreviations

Sir,
Drs McBride and McLellan (May Journal, p.217) seem to have proved their own point twice over. The sign $R_2$ means recipe, not recipio and in is redundant in ter (in) die sumendum and quater (in) die sumendum.

Misunderstanding may well be 'more likely among trainee general practitioners than principals', but is apparently not unknown among general practitioner authors.

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Sir,
In the survey of the use of Latin abbreviations mitre has been translated as give. I was taught do, dare, dedi, datum: to give or to offer. Surely mitte comes from mitto, mittre, to send or to let go — so the pharmacist is requested to send or release.

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Sir,
I found the paper on latin abbreviations by McBride and McLellan of interest. It is a difficult subject to treat scientifically and all that was lacking to this end was a statistical comparison of the scores, but I am glad that it did not go this far.

I take issue with the offered translation of the $R_2$ symbol. If it were Latin it would surely be recipe and not the infinitive. Its origins, however, are older than Latin and it is discernable in ancient Egyptian writings as the eye of Horus, a symbol of healing.

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Random case analysis and trainee assessment

Sir,
Dr Edwards (Letters, May Journal, p.229) draws attention to the use of retrospective random case analysis in his practice as an audit of patient care. I would like to describe the use of random case analysis as a method of formative assessment or 'educational' audit.

Random case analysis is a commonly used and powerful teaching technique in general practice which uses real cases as the principal source of material. During random case analysis sessions, areas in which the trainee is uncertain are discovered and, while some of these gaps
Patient or client?

Sir,

I was interested to read the letter from Rosemary Payne on a well woman advisory centre (March Journal, p.123).

What surprised me, however, was Dr Payne’s description of the users of the centre. ‘Client’ is used seven times and ‘patient’ never. While I agree that the word patient may not be appropriate, ‘client’ suggests a shopkeeper role for the doctor. I wonder how long it will be before we describe our patients as customers? Here in Israel there is a distinction between an ill person (cholel) and a well person under care (metropal). I have been unable to think of an equivalent in English to metropal. I believe that with the rapidly changing emphasis in primary care from treating illness to maintaining health it is time to introduce an equivalent to metropal. Perhaps your readers have some ideas?

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Use of cotton buds in the ear

Sir,

An external auditory meatus that has been traumatized and subsequently develops a secondary infection is a common clinical condition in general practice.

During the course of a recent surgery, I saw what for me was a new clinical sign. The first patient had a smooth hemispherical plug of wax blocking the canal that seemed to be almost polished and shiny. This was easily recognizable as the work of an energetically used cotton bud. Later that day a second patient presented, who also had a polished hemisphere of wax with a perfect circular hole through which the central portion of the tympanic membrane was easily visible. On this occasion the stick of the cotton bud had been pushed out of the cotton bud covering and on through the wax deep into the meatus.

I wonder how common a physical sign this is?

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Training in the North East Thames region

Sir,

As a course organizer in the blighted North East Thames region it was with some trepidation that I read the editorial ‘National minimum standards’ (June Journal, p.245). Naturally, the author takes the College line but I was impressed by the clarity and objectivity of the argument. However, there are several vital omissions which cast doubt on whether justice has been done, let alone actually been seen to be done.

1. Circumstances of the 1987 visit. It was apparently not made clear to the regional advisers, and certainly not to the course organizer involved, that the future of training in North East Thames region was dependent on the results of the 1987 visit to Bloomsbury by the Joint Committee on Postgraduate Training for General Practice. On the contrary, the visitors had requested that the practices chosen for the visit should include ‘those about which the regional adviser was particularly concerned’.

In this situation the joint committee should have said nothing and taken a chance, visited randomly chosen practices or requested to see substandard practices with a warning. To request to see poor practices without giving a warning of the outcome is underhand politics. However, the failure may not be in the visitors themselves. Perhaps we should ask them if they were aware of the invidious role in which they were cast?

No one disagreed with the visitors’ recommendations that the two trainers found wanting should not be reappointed. It is important to realize that these two individuals had not undergone the reselection procedure since 1985.

2. Discrepancy between the assessments of the regional officers and the joint committee visitors. Unfortunately, at the time the visit took place, the visitors did not inform the regional adviser of their dissatisfaction with the records of the poor practices. If they had done, a joint assessment could have been made. When the adviser heard of the dissatisfaction he immediately returned to the same practices and in his view the records were satisfactory.

I understand that visitors are not given guidelines as to the size of the sample which should be examined when the records are assessed. If the measurable is to be measured, it should be carried out with statistical accuracy and consistency.

3. Incomplete evidence. After they had received the 1987 report the regional officers prepared a response document which was sent to the joint committee. I understand that this document was not even made available to, let alone discussed by, the members of the joint committee at their meeting of 25 February 1988 when the critical decision was taken. I have heard no explanation for this.

A meeting took place between the officers of North East Thames and the of-