are dealt with immediately, others may be left for tackling at a later date. The method described here begins by taking the areas of uncertainty that are not immediately dealt with and listing them as 'learning needs', based on agreement between trainee and trainer. These statements can include learning needs from the cognitive, psychomotor and affective domains or any combination of these. The next stage requires the identification of suitable and accessible learning resources and here the trainer plays a particularly important role. The process moves on then to agreeing methods of resolving the learning needs, for example reading an article or visiting a hospice. It is important that the trainee organizes this independently — discovering and utilizing the resources described and seeking answers for areas of uncertainty that he or she has identified. The final important stage of assessing how well the learning needs have been met is difficult to achieve. It is an essential part of this 'learning contract'[1] approach to adult education that the method of assessment is agreed between the trainer and trainee at the outset. Assessment procedures that are built into the learning plan in this way can act as diagnostic aids and guides to progress. The methods used will vary but returning to the original source material, the clinical case, is a major element of this assessment process.

Feedback from trainees who have used this method on the half day release course in Chester emphasizes the central role that the trainee plays. Formalizing the learning process into clearly defined stages of identifying needs, choosing methods, finding suitable resources and assessing the effectiveness of learning introduces the trainee to the planning of learning which will be of value in their continuing medical education. Basing this educational method on random case analysis appropriately places the process of learning on the trainee's own experience within the context of clinical general practice.

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References

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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 *(choleh)* and a well person under care *(metoopal).* I have been unable to think of an equivalent in English to *metoopal.* 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 *metoopal.* 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 inviduous 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 taken place. 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-