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.

J.G. BLIGH

Lache Health Centre
Hawthorn Road
Chester CH4 8HX

References

1. Brookfield SD. *Understanding and facilitating adult learning.* Milton Keynes: Open University Press, 1986.

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?

MELVYN H. BROOKS

Tel Shalom
Pardess Hanna-Karkur 37000
Israel

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?

M.J.H. FISHER

Palmerston Street Surgery
Wolstanton
Newcastle under Lyme
Staffs ST5 8BN

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-

ficers of the joint committee in December 1987. There was no agreed minute of this meeting. A verbal report of the discussion was given to the joint committee meeting of 25 February by one of the joint secretaries of the joint committee. No evidence, either verbal or written, was heard from the North East Thames region.

I request that your readers bear these points in mind when they are considering the subsequent actions of the JCPTGP and RCGP.

HEATHER SUCKLING

Homerton Hospital
Homerton Road
London E9 6SR

Election of fellows

Sir,
In the past I have been involved in the nomination of fellows of the College, and I know that all the names put forward at a general meeting have been carefully considered. I have attended or read about every general meeting held by the College, and I cannot recall a single instance when I would have wished to cast a negative vote on a proposal to elect a fellow.

Despite this, I am uneasy about a procedure by which the names of those proposed for election are not made available until the meeting. There might be a candidate who could not be unreservedly supported, and one would prefer that this could be established before the day itself. More happily, the friends of colleagues soon to be welcomed as fellows might wish to make a special effort to attend if they knew in good time who was to be nominated. Election of fellows is an important matter, and those who attend the meeting should be able to form opinions in advance.

Printing the names of nominees in the agenda for a general meeting might be inappropriate, but they could be formally published beforehand on a notice board at Princes Gate for 28 days, as is the custom at the Royal Society of Medicine. During that time they could also be made known by the general administrator to any member or fellow who enquired. By some such means the possibility of a mishap could be made still more remote, the pleasure of the occasion could be made known to some who might otherwise miss it, and those present at the meeting could know that they had had an opportunity to consider this item of business with the care it deserves.

G.W.C. JOHNSON

30 Sunderland Avenue
Oxford OX2 8DX

Fellowship by assessment

Sir,
I am sorry that John Kelly (Letters, May *Journal,* p.230) should be concerned about what he perceives to be a concerted campaign to abolish the present method of election to fellowship of our College.

The fellowship by assessment working group of the College in no way seeks to denigrate those who have had the honour of fellowship bestowed upon them by the current process. However, there is good evidence that there are inconsistencies within faculties, including one faculty that operates no system at all. In addition, an increasing number of members are stating that they do not wish to be considered for fellowship unless this is achieved by a rigorous process of assessment by peer review. We are currently seeking to establish a set of principles that will form the foundation for the development of such a process.

Given that our College is publicly committed to high clinical standards and performance review it is logical to turn to our future fellows to demonstrate good clinical care. The major difference from the current process would be the rigorous practice-based assessment of the clinical care of patients by the doctor concerned. In this way fellowship would continue to be an honour representing the highest grade of membership of our College to which I would hope our many young members would seek to aspire.

PETER HILL

11 Beechfield Road, Gosforth
Newcastle upon Tyne NE3 4DR

Sir,
Dr John Kelly raises some important issues about fellowship by assessment. As one who supports the introduction of fellowship by assessment, I would like to offer some comments.

Dr Kelly is absolutely right that the present system of fellowship by nomination should not be denigrated. Nomination by peers is based on close knowledge of the person, and the quality of his or her practice and work within the College over a length of time, and is therefore a particular and very special honour. I have participated in the nomination of doctors to fellowship, and so would be deeply offended by the suggestion that fellowship by assessment is better than fellowship by nomination, and that the fellows so identified are in some way 'better'. Fellowship based on assessment of the quality of clinical care of the doctors concerned deserves support because it will enable the College to demonstrate its commitment to improving clinical standards in general practice. This issue is at the core of all the present arguments about the future of general practice, and so the College must be seen to practise what it preaches.

Fellowship by assessment then, is not better than fellowship by nomination, but it is different. That difference is necessary because it is demanded by the world in which medicine will be practised in the 1990s.

R.H. BAKER

'Lloyd Davies House'
17 Moorend Park Road
Cheltenham GL53 0LA

Sir,
I understand that fellowship of the College by assessment will be introduced in the near future. Fifteen years ago I was 'examined' and have subsequently been pleased to call myself a member. At the earliest opportunity I shall submit myself for assessment, and hopefully my standards and practice will be considered appropriate and I shall be equally pleased to call myself a fellow. Perhaps to retain this title I shall have to be reassessed at regular intervals. So much the better. In the event of my being found wanting I shall be a lot less complacent, and will have to raise my standards so that they meet with the approval of my peers.

I.D. KERR

Clare House
Tiverton, Devon EX16 6NJ

Car appreciation courses

Sir,
Is it not time for the College to start running car appreciation courses. These could introduce members to the working of the internal combustion engine, give them experience of simple repair jobs and car tuning, and 'hands on' experience of driving a car.

After this members could form 'car user groups' and meet to discuss the problems they meet in day-to-day motoring. They could also bring pressure to bear to ensure all vocational trainees were given a basic grounding in cars during their training and even push for regional advisers in motoring to facilitate their use in practice.

Perhaps this is not required because most doctors will just want to drive their car and leave its inner secrets to their local mechanic when they have problems. If they are unhappy about driving they might even employ someone to do it for them. After all cars are just a tool for us to use in general practice, not the main purpose of our existence...just like computers?

GEORGE TAYLOR

41 Clayton Road
Jesmond, Newcastle upon Tyne NE2 4RQ