seen per month seems to be similar. This implies that the introduction of a nurse led children's surgery has not increased the consultation rate. It has, however, greatly decreased the doctors' workload. Other general practitioners may be considering the introduction of such a service, and our experience seems reassuring. It is important, however, to assess the quality of these nurse led consultations.

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Busy is a weasel word

EDITOR,—The technical editor's blue pencil must surely have hovered at least momentarily over the title of G N Marsh and M L Dawes's paper.¹ Like supermarkets that use the exhaust fumes from the in house bakery to make the entrance smell wonderful, every article's title should of course entice readers to go further. But doesn't the word "busy," even if it appeals to every general practitioner's Monday morning near paranoia that the floodgates of demand are about to open, belong more to advertising than to science? Busy, when hooked up to general practice, is a weasel word, to use the advertising industry's term, and is as meaningless as "farmhouse" attached to butter or "home baked" attached to cake: that hovering blue pencil should have struck it out, not moved on.

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Preregistration house officers in general practice

Regulations limit approved institutions for training

EDITOR,—Joe Wilton's paper shows the considerable benefit of young doctors acquiring preregistration experience as house officers in general practice.¹ We believe that the arrangements for this should be extended throughout Britain so that there are more opportunities for such popular and profitable attachments.

Regrettably, such experience can be acquired only in an "approved institution," and section 12 of the Medical Act 1983 limits such approval to health centres. This we believe to be illogical for there are many excellent practices and would-be teachers who are not based in health centres and whose participation would enable preregistration experience to be readily obtained in general practice. It seems that a new Medical Act would be required before the necessary changes could be brought about. We are concerned at the reluctance of those involved, and in particular the General Medical Council, to move in this direction, and we urge that the necessary legislation be enacted as quickly as possible.

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Problems will arise over who pays

EDITOR,—None of the references cited in Joe Wilton's article on preregistration house officers in general practice dates from before 1987.¹ I have reported the experience of house officers attached to a practice in Runcorn, Cheshire, that was associated with a university in 1981 and 1982.² I described the basis for the scheme and the way in which the attachments worked, including components of learning and methods of supervision. I also raised the need for clarification of administrative aspects such as finance and terms of employment. The "Runcorn scheme" founded in 1982 after a promising start because of the predictable question, "Who pays the general practitioner house officer?" and implicit fears that a popular community scheme for preregistration house officers might in some way threaten the size of the pool of young doctors required to staff the hospital service.

I wonder whether these aspects have been addressed effectively enough to make a nationwide scheme realisable in the foreseeable future.

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2 McGuinness BW. A house officer attachment in general practice. *Practitioner* 1982;226:1216-7.

Training in general practice is also important for postregistration doctors

EDITOR,—We were encouraged to read Joe Wilton's description of the progress made in including general practice as part of the preregistration year at St Mary's Hospital Medical School.¹ His results confirm that general practice provides many educational opportunities, including increased clinical activities and longer teaching times compared with those for house officers based in hospitals. It is disappointing that this is the only established preregistration rotation in England. One wonders why this valuable experience is neglected elsewhere and why its development is not given a higher priority.

A similar situation exists with training at senior house officer level, with calls by many bodies to develop attachments in general practice for fully registered junior hospital doctors.^{2,4} Unfortunately, there is no evidence that progress in this has been any better.

We are in our second year of evaluating the benefits of linking an established senior house officer rotation in hospital medicine based at Newcastle General Hospital to a general practice post with the Northumbria vocational training scheme for general practice. This rotation provides young doctors who are either intent on a career in hospital medicine or undecided about a career with an opportunity to sample and learn from general practice. This has required much planning and coordination by a steering group comprising consultants, trainers in general practice, and course organisers for the vocational training scheme. A joint appointments committee selects trainees, who undertake three posts each of four months' duration, one of which is in an established training practice. A curriculum is fashioned in the general practice post to suit individual trainees' needs, with an emphasis on communication skills, teamwork, prescribing, record keeping, and the psychological and social aspects of patients' problems. Educational aspects include protected teaching time, attendance at the vocational training scheme's academic course, and an emphasis on formative assessment and feedback.

It is good to see some progress with the pre-

registration year, but we believe that innovation is long overdue in the education and training at senior house officer level. The way forward must be through experimentation with, and evaluation of, different models of training. Only then will progress be made in ensuring that these doctors receive training and education that have appropriate breadth and depth.

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2 Council for Postgraduate Education in England and Wales. *On the provision of experience in general practice for intending hospital specialists*. London: CPEEW, 1987.

3 Royal College of Physicians of London. *General professional training—the Royal College of Physicians guide for trainees and trainers*. London: RCP, 1994.

4 Department of Health. *Report on the working group on specialist medical training. Hospital doctors: training for the future*. London: DoH, 1993.

Posts are purely educational

EDITOR,—The evident success of the preregistration rotation in general practice based at St Mary's Hospital over the past decade¹ is a tribute to its originator, Harris,² and to the dedication of subsequent teachers both in practice and in hospital. This training opportunity has always been educationally attractive, and I have often been asked why it is not more widespread. Some of the reasons were discussed when Coles and I reported the original scheme in Southampton in 1982.³ In particular, there is no essential service role for a preregistration house officer in general practice; the post is therefore purely educational, and the teaching needs to be paid for. It is interesting that Joe Wilton, in his account,¹ makes no reference to the costs or how they are met. I understand that both the regional health authority and the special trustees of the medical school contribute. When a trainer in general practice takes a trainee he or she gains a training grant (currently £4840 a year) as well as a (so called) free pair of hands from a competent young doctor who wants to make his or her way in general practice. I believe that to make preregistration attachments more generally feasible a considerably greater financial incentive for the trainers may be required.

The traditional service role for hospital preregistration house officers is the main obstacle to progress. As long as this persists and only lip service paid to education a general practice option is bound to seem expensive with its greater emphasis on education. Now that postgraduate deans have direct financial control over all junior hospital posts the time is surely ripe for a more flexible approach to apprenticeship in the preregistration year. General practice could play a much enhanced part. This could be a training path for a large proportion of junior doctors, whether they ultimately make careers in general practice or in hospital. Let there be no mistake, though: we must face up to the funding issues in concert with the educational benefits.

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Services for cleft lip and palate

Maxillofacial surgeons use strict surgical protocol

EDITOR.—It is important to debate the problems of the apparent poor results of surgery for cleft lip and palate.^{1,2} As editor of the specialist journal I note some important developments.

The authors of the paper and letters on the subject may not be aware of an important initiative being taken by a group of maxillofacial surgeons (current estimates suggest that up to a fifth of primary clefts in England and Wales—and most in the rest of Europe—are treated by this specialty). This initiative entails using a strict surgical protocol in conjunction with regular audit or outcome. One clinician closely supervises the surgical technique and interpretation of the surgical protocol. At present, about 120 patients are monitored a year.

This is a particularly exciting project as it is also being extended to France and Germany. This process clearly overcomes the problems of small numbers for audit and also allows a more convenient, local service to be provided for patients. The important part played by local paediatricians may also be enhanced. Incidentally, the surgical technique involves a different philosophy, placing much greater emphasis on a "functional" repair, and early results show great promise (J P Hayter; S D Adcock; meeting of British Association of Oral and Maxillofacial Surgeons, 1995).³

It may be an error in this controversial issue to rush headlong into expensive and inconvenient (for patients) centralisation without good scientific evidence that it will improve results. Indeed, plastic surgery has traditionally operated from regional centres, yet, sadly, the outcome for cleft lip and palate at these "centralised" units has formed the basis of some of the studies by Williams and colleagues and the apparent poor outcome.

There are many other elements to good outcomes. Surely the frequency with which a surgeon operates in the mouth and jaws must be of great relevance in the decision on how many operations for cleft lip and palate he or she must do to be competent. Trying to define the "correct" number of cases is a nightmare. The rate of stroke after carotid endarterectomy drops from 7% to 3% if the surgeon performs over 10 operations a year.⁴ Yet of the 16 surgeons who performed a low number of operations, seven had had no patients with stroke in three years, which suggests that number of operations is not the only criteria for success. These are complex issues that need broad, careful consideration and much more scientific evaluation.

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- 1 Williams A, Shaw WC, Devlin HB. Provision of services for cleft lip and palate in England and Wales. *BMJ* 1994;309:1552. (10 December.)
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Surgical caseload is only one variable that influences outcome

EDITOR.—Recent studies have highlighted deficiencies in the overall standard and organisation of repair of cleft lip and palate in England and Wales, but, contrary to the opinions expressed in these papers, there is no conclusive evidence that surgical caseload is a critical factor in determining outcome.^{1,2} In a retrospective European multicentre study the number of operations carried out by an operator was just one of several variables that may have influenced the outcome of treatment in patients with cleft lip and palate.¹

Alison Williams and colleagues admit that the minimum number of primary cleft repairs that a surgeon should undertake each year is not known.² They go on to suggest, however, that an annual caseload of 40-50 repairs would be desirable and cite a report by the Standing Dental Advisory Committee as the source of this recommendation. Unfortunately, this report has not been published and it is therefore impossible to comment on the validity of this figure.

Although there is a strong case for centralising many specialist surgical services, there is little evidence to support the unqualified acceptance of this process for services for cleft lip and palate. The advantages of local treatment are often dismissed as secondary considerations, but having to travel long distances regularly may present considerable problems for young families. Contrary to the views expressed by P J Sykes, it is not surgeons, managers, or purchasers but paediatricians who are often keen to instigate local services for cleft lip and palate as they are sympathetic to these problems and are concerned about the lack of coordination that often exists between local and centralised services.³ In some areas local services have been developed as a consequence of patients' dissatisfaction with the regional service.

While there is no place for "occasional" cleft lip and palate surgeons, there is no reason why local units with the necessary multidisciplinary skill cannot cooperate in an effective multicentre treatment programme and thereby provide the caseload necessary for meaningful clinical audit. This is precisely why maxillofacial surgeons involved in the primary management of cleft lip and palate in England and Wales have established a multicentre audit, based on a well defined treatment protocol. Such initiatives should be encouraged as they provide an opportunity to improve the standard of management of cleft lip and palate, which has been dominated by clinical dogma for too long.

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The fibromyalgia syndrome

Outcome is good with minimal intervention

EDITOR.—Michael Doherty and Adrian Jones paint an unnecessarily pessimistic picture of the outcome in patients with the fibromyalgia syndrome.¹ They say that patients "cannot cope with a job or ordinary household activities" and that "the prognosis for fibromyalgia is poor." They base this on the one study in a British hospital population. Such populations will contain patients

with worse symptoms, comorbidity, and psychosocial stress. The busy, practical, and focused outpatient care that might be suitable for dealing with many rheumatological problems may not be suitable for fibromyalgia, which often requires protracted counselling and multidisciplinary strategies.

Furthermore, most people with this condition do not attend hospital clinics but are seen in the primary care sector. Studies of this group have shown a good outcome with minimal intervention.² Observations of patients in community referral rheumatology practices in Australia indicate a considerable improvement with appropriate intervention. This is not to say that many patients do not have a chronic disabling condition, but the adoption of a positive approach to outcome is appropriate. Linking the diagnosis of fibromyalgia with a poor outcome can become a self fulfilling prophecy and inappropriate medical dogma. This may preclude appropriate strategies that might otherwise greatly improve patients' quality of life.

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- 2 Granges G, Zilko P, Littlejohn G. Fibromyalgia syndrome: assessment of the severity of the condition two years after diagnosis. *J Rheumatol* 1994;21:523-9.

Electroacupuncture is a potentially valuable treatment

EDITOR.—In their review of fibromyalgia¹ Michael Doherty and Adrian Jones omit to mention electroacupuncture, which is a potentially valuable treatment. Deluze *et al* described a controlled study of 70 patients who met rigorous criteria for the diagnosis of fibromyalgia.² The group that was treated with electroacupuncture showed highly significant improvements in seven of the eight variables measured. Most importantly for the patient, pain scores improved by 70%, whereas they increased by 4% in the control group. The pain threshold was raised, as assessed by pressure gauge, and the evaluations made by the patients and the (blinded) examining doctor also showed highly significant improvements.

Deluze *et al* presented results as mean scores for the whole group, which conceals the fact that symptoms almost completely disappeared in a quarter of the patients given electroacupuncture. The research needs repeating, and follow up studies are necessary; meanwhile, such an important finding should not be neglected. Doherty and Jones's conclusions about the poor prognosis for fibromyalgia look unnecessarily pessimistic.

Modern acupuncture is now a reproducible technique that can be easily learnt by doctors and can be subjected to rigorous trials. Its physiological effects include the release of neurotransmitters³ as well as deactivation of trigger points.⁴ Acupuncture seems to retain its effectiveness even when much of its Chinese philosophical background is discarded, although many empirical observations need a good deal of further research.

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