but zygosity has no effect on the risk of disease for either male ($P=0.23$) or female twins ($P=0.63$).

John A Davis's points about environmental factors such as infection and diet are important. In fact, in our paper we argued against uncritical use of estimates of heritability and for in depth studies of concordance according to zygosity and the co-occurrence of immunological markers and susceptibility genes. Davis's points about monozygotic twins being reared differently from dizygotic twins and being of a lower birth weight would imply a higher prevalence of disease in monozygotic than dizygotic twins. However, we have found exactly the same prevalence of disease in monozygotic and dizygotic twins, similar to that in the general population.

KIRSTEN OHM KYVIK
Research assistant lecturer
ANDERS GREEN
Research lecturer

Genetic Epidemiology Research Unit,
Institute of Community Health,
Odense University,
DK-5000 Odense,
Denmark

HENNING BECK-NIELSEN
Professor

Department of Endocrinology (M),
Clinical Research Institute,
Odense University Hospital,
Odense

Use of predeposit autologous blood transfusion varies greatly

EDITOR,—As Bryan Christie points out, in the United States the use of predeposit autologous blood transfusion for certain surgical procedures such as planned orthopaedic surgery is high.¹ This is not only because of increased demand by patients but also because doctors consider it prudent, for clinical as well as legal reasons, to inform eligible patients of the availability and advantages of this procedure.²

In Britain predeposit autologous blood transfusion is relatively uncommon and mainly confined to the few units where surgeons and anaesthetists are keen to promote it. Few patients in Britain request it without being prompted. We believe that surgeons and anaesthetists need to provide information to eligible patients at assessment clinics to enable them to choose this option. This view is supported by figures collected by our regional blood service centre, which show widely varying rates of referral for predeposit autologous blood donation among the 22 hospitals served by the centre as well as among individual surgeons. Table 1 shows the variation among five of the hospitals. Some of the orthopaedic surgeons and anaesthetists in hospitals A and B have a policy of reminding suitable patients of the option of predepositing their own blood before their planned operation. In other hospitals it is up to the patient to request this option. In addition, even at the same hospital, some orthopaedic surgeons are more likely than others to refer patients for predeposit autologous blood donation: at hospital A, over five years, one surgeon referred 262 patients, one referred 193, one referred 57, one referred 30, and the remainder referred five.

Similar variations probably occur in other regions of Britain. The reasons for them need to be explored by teams of representatives from appropriate disciplines.

FG RUSHAMBUZA
Consultant haematologist
VJ MARTLEW
Consultant haematologist

National Blood Service,
Mersey and North Wales Centre,
Liverpool L7 8TW

- 1 Christie B. Autologous blood transfusions need risk register. *BMJ* 1995;311:971. (14 October.)
- 2 Williamson KR, Taswell HF. Avoiding the hazards of homologous blood transfusion, and other advantages of autologous blood transfusion and hemotherapy. In: Taswell HF, Pineda AA, eds. *Autologous transfusion and hemotherapy*. Oxford: Blackwell Scientific, 1991:22-52.
- 3 Department of Health. *Ordinary and day case admission for England. Financial year 1993-94*. London: Statistics Division 2, DoH, 1994.

Inquiry is needed into difficulties of developing academic careers

EDITOR,—The Wellcome Trust agrees with the recommendation in the Walton report that an independent inquiry should be held into the disincentives facing young men and women who wish to develop a clinical academic career. This recommendation is also supported by both Richard Smith¹ and John Walton.²

Excellent young clinical scientists continue to apply to the Wellcome Trust for their support as training fellows and senior fellows. In many major specialties, however, it is becoming more difficult to combine an academic career with clinical practice. Clinical scientists are finding increasing difficulty in meeting the demands of specialist clinical training while at the same time developing their academic career. Those who are successful in both clinical and research work are often loth to take an established academic appointment because the pressures of teaching, administration, and clinical work are so great as to be inimical to good research.

Smith is right in pointing out that problems in clinical academic careers are not new, and we must remember that university based clinical research is relatively modern, being a product of the last century.³ The novelty of the discipline and the chronicity of its problems, however, are not arguments for deferring a serious effort to solve them. The trust hopes that there will be an urgent inquiry into these problems and into the need to nurture academic careers.

BRIDGET M OGILVIE
Director

Wellcome Trust,
London NW1 2BE

- 1 Smith R. Their lordships on medical research. *BMJ* 1995;310:1552. (17 June.)
- 2 Walton J. Their lordships on medical research. *BMJ* 1995;311:510. (19 August.)
- 3 Booth CC. Clinical research. In: Bynum WF, Porter R, eds. *Companion encyclopaedia to the history of medicine*. London: Routledge, 1993.

Career choices of trainees in general practice

EDITOR,—The career choices for generation X that Clare Vaughan discusses in her editorial¹ were reflected in a survey of 52 trainees due to complete their vocational training in North Trent last year. Fifty (96%) trainees agreed to be interviewed (median age 28.5 years for both the 23 men and 27 women). Most had been to a British university (mainly Sheffield), most were married, and 17 had a family. The commonest stage at which

they had decided to enter general practice was as a clinical student or during their first post as a senior house officer; the reasons given for their decision were continuity in the community, dislike of hospital, variety, lifestyle, and independence. Training was considered to have been poor during the preregistration year but to have improved during the vocational training scheme. Many had found their workload too onerous, especially in junior hospital posts, when 15 had felt very ill owing to overwork but had not taken time off, eight had taken odd days off owing to severe stress, and 10 had had one week or more off owing to disease induced by stress.

Only seven were willing to undertake a full on call commitment in the future, and 32 wished to use a partial deputising service. Eleven (most of whom were women) did not wish to have any out of hours commitment. Twenty three would advise against medicine as a career and only 17 were in favour of it, while the remainder were equivocal. The reasons given were low pay, hours of work, stress, and poor job satisfaction. Only five were completely happy in their career.

Most of the trainees wished to join a medium sized partnership with full ancillary and attached staff, but 34 stipulated that deputising should be available. Only four were willing to work in an inner city or deprived area, but two were willing to take on a substandard practice and improve it. One trainee wished to work single handedly. Only 20 wanted to undertake some form of research or audit, and only 12 were interested in teaching. Although training in general practice was regarded positively, the trainees' plans showed prevarication, with few willing to take on principal status with full 24 hour commitment; findings in other studies have been similar.^{2,3} In addition, most of the women did not wish to become full time principals, which indicates the need for more flexible working patterns and for part time work to be reflected in predictions of staffing.

ROSEMARIE WEBB
General practice course organiser

South Axholme Group Practice,
The Surgery,
Epworth,
Near Doncaster,
South Yorkshire DN9 1EP

DAVID HANNAY
Professor of general practice

Department of General Practice,
Northern General Hospital,
Sheffield S5 7AU

- 1 Vaughan C. Career choices for generation X. *BMJ* 1995;311:525-6. (26 August.)
- 2 Beardow R, Cheung K, Styles WMcN. Factors influencing the career choices of general practice trainees in North West Thames Regional Health Authority. *Br J Gen Pract* 1993;43:449-52.
- 3 Kelly DR, Murray TS. Twenty years of VTS in West Scotland. *BMJ* 1991;302:28-30.
- 4 Johnson N, Hasler J, Mant P, Randall T, Jones L, Yudkin P. General practice careers: changing experience of men and women vocational trainees between 1974 and 1989. *Br J Gen Pract* 1993;43:141-5.
- 5 Baker M, William J, Petchey R. GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. *BMJ* 1995;310:1301-4. (20 May.)

Concerns about "lookback" exercise for hepatitis C

EDITOR,—Nigel Higson identifies two issues that we have raised with the deputy medical officer regarding the "lookback" exercise to detect recipients of blood products donated by donors found to be positive for hepatitis C.¹ The first issue is the inappropriateness of counselling and advice being given by medical practitioners who do not have up to date knowledge about hepatitis C. Our experience bears this out.

With any new virus it is to be expected that information will take time to filter through, and a fast changing and often apparently contradictory

Table 1—Varying rates of referral for predeposit autologous blood donation at different hospitals

Hospital	No of orthopaedic inpatients/year*	No of referrals*
A	2846	547
B	3335	152
C	2855	3
D	3147	0
E	2355	10

*In five years.