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.

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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.

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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.

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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.

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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.

knowledge base adds further to the difficulty. The British Liver Trust is attempting to address this issue by providing specific and updated information on hepatitis C, its diagnosis, and its treatment for both patients and general practitioners. We have also had meetings with, among others, the blood transfusion service to agree a method of managing and counselling people with hepatitis C.

We are currently attempting to elicit funding to provide a central post to coordinate advice and information on hepatitis C. Such a central resource would overcome the problems that occur because general practitioners see only one or two patients. It would also help to ensure that patients have tests specific to hepatitis C, are referred to specialists, and are given appropriate advice when dealing with issues such as insurance and endowment policies.

The second issue that Higson highlights is the fear of false negative results. A television programme on hepatitis C last year (BBC1, *Panorama*, 16 Jan 1995) resulted in 3000 calls to the trust. Many of these were from people who had received one or multiple transfusions before September 1991. As the lookback study does not trace such people, we would urge all those who fear that they might be at risk to ask their general practitioner for a test and, if the result is positive, for referral to a specialist.

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Hospital patients in Bosnia are nutritionally vulnerable

EDITOR,—Josephine Vespa and Fiona Watson's paper describing nutritional vulnerability in elderly people during the Bosnian war reminds us that not only missiles give rise to casualties.¹ The onslaught against Sarajevo and other enclaves massively reduced supplies of fuel, running water, and food. Not surprisingly, the weakest suffer most in such circumstances. The authors fail, however, to recognise another group of highly vulnerable people—namely, those who have been wounded. At least 600 000 Bosnians have suffered injuries in this war, and their special nutritional needs have never adequately been addressed.

Our studies, done in collaboration with Humanitarian Aid Medical Development, have shown the effects of inadequate nutrition on wounded patients in hospitals. After making their first visit to Sarajevo in August 1993 the surgical teams noticed deterioration of the patients with each return visit. This coincided with the reduction in food supplies as the city became totally dependent on an airlift, which would have been inadequate even if completely successful; adverse weather and hostilities reduced the airlift to 65% of the possible total capacity.

Food supplies in Sarajevo were in a parlous state by November 1993, when we decided to abandon an extensive, elective surgical programme because of a substantially increasing incidence of wound dehiscence and infections. In this decision we were supported by our colleagues in Sarajevo. By January 1994 the infection rate had nearly tripled (unpublished findings), and Humanitarian Aid Medical Development's nutritionist showed an average weekly weight loss of 1.8 kg in male patients at the state hospital (unpublished findings). Additionally, many uninjured inpatients were severely malnourished owing to the inadequate food supply.

Unfortunately, adequate consumption of Kings

Recovery Food, the synthetic supplement provided and recommended by the World Health Organisation, required 3 litres of water daily; the supplement is a sweet, unpalatable product. The high saccharide content caused diarrhoea, and the city's uncertain water supply produced obvious difficulties. Our attempt to provide a monthly air load of nutritious, palatable food dedicated to hospital inpatients was vetoed even though agreement was obtained from the United Nations High Commissioner for Refugees. The patients' inadequate nutritional status was obviously due to the combination of the deficiency of supply and the increased requirements resulting from the effects of polytrauma and underheated hospitals.

Our experience of injured patients with inadequate food supplies accords with that of experts who have shown that seriously ill patients are at risk even in peacetime in hospitals when the physiological requirement for increased nutrition is not fully appreciated.²

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Moving house unlikely to pose substantial risk of childhood asthma

EDITOR,—C H Hughes and J H Baumer report a remarkably strong association between childhood asthma and number of household moves in their general practice population and suggest that this relation needs to be studied elsewhere.¹ Although their paper focuses on the number of moves before the onset of the disease, the proportion of children being treated for asthma who had moved house at any age differed substantially from the corresponding proportion of controls (86% v 36%, odds ratio=11.1 by unmatched analysis). We have analysed in a similar manner the relation between a lifetime history of household moves and childhood asthma in two case-control studies and one cohort study of British children.

Among teenage children in Sheffield 71% (390/548) of those with severe wheeze had moved since birth, compared with 66% (348/530) of controls matched for age and school.² The corresponding odds ratio is 1.29 (95% confidence interval 0.99 to 1.68). These results include those in children who had moved in the past three years and were therefore excluded from previously published analyses.²

Among 8-9 year old children in Croydon 66% (192/293) of those with asthma or wheeze in the past year had moved since birth, compared with 65% (181/280) of their classmates with no history of asthma or wheeze (odds ratio=1.04 (0.74 to 1.47)).³

Among members of the British 1958 birth cohort followed up to age 16, 25% (1695/6666) of

those who had moved at least once between birth and age 16 were reported to have developed asthma or wheezy bronchitis by age 7, 11, or 16, compared with 22% (448/2009) of those who had not moved house over the same period.⁴ The incidence odds ratio associated with any household move is 1.14 (1.04 to 1.25). Although this is significant ($P<0.01$), it indicates only a small increase in lifetime risk associated with a history of moving house. There was a weak ($P<0.001$) trend of increasing lifetime incidence of asthma or wheezy bronchitis with increasing numbers of household moves (table 1).

Table 1—Incidence of asthma or wheezy bronchitis from birth to age 16 in British 1958 birth cohort, by number of household moves by age 16 (restricted to subjects followed up at ages 7, 11, and 16)

No of moves	No of children	No with asthma or wheezy bronchitis	Incidence by age 16 (%)	Odds ratio (95% confidence interval)
0	2009	448	22.3	1.00
1	2987	719	24.1	1.10 (0.97 to 1.26)
2	1674	412	24.6	1.14 (0.98 to 1.33)
3	934	235	25.2	1.17 (0.98 to 1.40)
≥ 4	1071	329	30.7	1.54 (1.31 to 1.83)

The results of these population based studies are consistent with a small increase in the risk of wheezing among children whose families move house. The upper limit of the confidence interval, however, excludes by some considerable margin an odds ratio of 11.1.¹ We conclude that moving house is unlikely to pose a substantial risk of initiating or exacerbating childhood asthma and suggest that chance variations or confounding factors specific to the authors' practice area underlie the strong association that they observed.

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Does the patient prefer Asti Spumanti or Chateau Lafitte?

EDITOR,—Colin Douglas suggests that general practitioners should be labelled in the way that wines are labelled so that patients can choose one who is appropriate for them.¹ What he fails to perceive is that one of the skills of being a general practitioner is to be Asti Spumanti to those patients who like Asti Spumanti and Chateau Lafitte to those who prefer Chateau Lafitte.

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