five cellular components for use in paediatrics. Furthermore, transmission may be compounded by secondary infection of sexual partners and offspring.

The cost of preventing a single transmission of the virus has been estimated as £30 000 and the cost of preventing each case of HTLV associated disease as £1.3 million.⁴ With the higher rates of transmission extrapolated above, these figures would be more than halved. Selected screening has been proposed as a cheaper alternative to blanket testing of blood donors. However, selecting whom to screen on the basis of ethnic origin is unlikely to prevent viral transmission. Ethnic origin did not predict HTLV infection in four of the five infected donors in the north London study,⁴ nor two of the three HTLV-I positive donors in a Dutch study of selective screening.¹³ Two of the five infected donors in London and one of the three in Holland had no identifiable risk factors for HTLV infection,^{4,13} suggesting that exclusion based on a detailed sexual history is unlikely to prevent transmission

either. An alternative approach is to screen first time blood donors. This strategy is being used in Sweden, where the prevalence of HTLV infection is approximately half that in Britain.¹²

Deciding not to screen for HTLV-I may prove to be a false economy. Recent experience with hepatitis C has shown that the cost of tracing and testing donations retrospectively is considerable and legal costs are likely. Surely the case for screening for HTLV-I in Britain is now clear.

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New incentives for general practitioners in London

An opportunity that must not be wasted

The London Initiative Zone, encompassing an area of about 16 km radius from Piccadilly Circus, was set up by the Department of Health in 1993 "to concentrate attention and resources on developing primary care in the inner city."¹ Since then there have been schemes to improve general practice premises and expand primary care teams and community health services. General practice is the focus for primary care in Britain; but contented, keen doctors are likely to provide better care than unhappy and frustrated ones, and the morale of general practitioners in Britain has been steadily deteriorating.² The Royal College of General Practitioners and the BMA's General Medical Services Committee have established task groups to review professional recruitment and morale and recommend ways of improving them.^{3,4}

Low morale has many causes, including increasing workload and professional isolation, inappropriate administrative tasks, unrealistic patient expectations, and an uncertain future. In London as in other large cities, high costs, social deprivation, a high turnover of patients, and the impact of closing hospital beds all combine to increase stress, while vocational training often fails to equip doctors with skills necessary for inner city practice. Other important reasons for decreased job satisfaction and failure to recruit general practitioners include a lack of protected study time to keep up with the advance of medical knowledge (an absolute requirement for all clinicians) and lack of opportunity for careers to evolve and develop.⁴ Many practitioners feel more

fulfilled if they can combine patient care with teaching, a clinical assistantship, or research. Many recently trained practitioners do not want to plunge immediately into full time clinical work. Kirwan and Armstrong report lower levels of "burn out" among part time family doctors.⁵

Two initiatives have recently been launched to address these problems within the London Initiative Zone. The educational incentives programme will use a variety of educational routes to aid recruitment and enhance job satisfaction in general practice, while the workforce flexibilities programme will use financial incentives to attract practitioners and develop practice services. The educational incentives are open to all general practitioners within the London Initiative Zone, but the financial incentives are restricted to single-handed and twohanded practices. Funding is from money new to the NHS, and substantial sums are involved. Between them the programmes will receive a total of up to £35m, and they are currently funded up to 31 March 1997. Both will be evaluated.

The central part of the educational incentives programme is the funding for several hundred (from a total of over 1500) general practitioner principals within the London Initiative Zone, allowing them to take time off clinical work for professional development, to introduce new services, or to undertake undergraduate or postgraduate teaching. Fellowships are being established for young doctors to develop teaching and research skills and to work part time in

practices where additional clinical support is needed for service development. Variations to the vocational training scheme are also being piloted. Some general practitioner registrars will spend more of their three year course in general practice; others will have a fourth year of academic training in a department of general practice. Funds have been allocated to these departments and to the relevant family health services authorities in proportion to the number of general practice principals in their area.

Good collaboration will be essential if this scheme is to succeed. Local education boards, comprising representatives of all interested parties, will consider applications for funding; in some districts these exist already, in others they have had to be created. Boards should not merely respond to bids from practitioners and from education providers: a proactive approach is needed. However, it is difficult to commission a programme of education when it is uncertain whether funding will be available after two years.

Doctors in the programme will need substantial academic support from university departments of general practice—to provide training in research, teaching, and information technology—and from the postgraduate education network. For example, clinical tutors in general practice will visit practices to discuss the opportunities offered by the London Initiative Zone educational incentives programme, an important and innovative role. The programme presents an excellent opportunity to develop an integrated approach to education.⁶ It could create the exciting prospect of a continuum for general practitioners in London: from undergraduate education, through a stimulating vocational training scheme, towards a well planned programme of continuing professional development.

The second initiative is the workforce flexibilities programme, which has just been introduced to general practitioners within the London Initiative Zone through an amendment to the Statement of Fees and Allowances.⁷ It provides a guaranteed income for doctors newly appointed to singlehanded vacancies and encourages singlehanded and twohanded practices to work together, share resources, and develop a wider range of services. There are also new allowances for general practice assistants. To qualify for the programme, practitioners must agree practice development plans with their family health services authority. The requirements can be locally negotiated, but might include a commitment to develop a practice formulary, undertake clinical audit, or organise and summarise patients' records. These are

tougher conditions than those required of doctors taking part in the educational incentives programme, and it will be interesting to see how practitioners respond.

Both the programmes are welcome. However, the timescale is unrealistic. In an ideal world the educational incentives programme would grow out of a London-wide assessment of the educational needs of general practitioners and the barriers to meeting them; but in the real world the money has been announced first and guaranteed initially for only two years, and it has taken six months to prepare for local implementation and receive authority to spend. The remaining 18 months are not long enough to give all general practitioners in the London Initiative Zone, especially those who are most disillusioned and overburdened, an opportunity to take "time out" for further education. It is likely that the first to take up the scheme will be the younger and more enthusiastic practitioners who have already decided on the education they would like.

The present time frame may be too short for the programmes to achieve their prime objectives: to improve the morale and expertise of a significant number of established general practice principals in London and attract more than a handful of new doctors to work in the inner city. Both programmes need to be extended for at least a third year. If successful they should lead to similar projects for recruiting and invigorating general practitioners in other urban areas.

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Outpatient follow up

Who benefits: doctors or patients?

One of the first questions that trainee surgeons learn to ask a new boss before the first outpatient clinic gets under way is, "Do you routinely follow up all your patients?" The reason the question needs asking is that some consultants do and others don't. The paper in this issue by Alison Waghorn and colleagues (p 1344) confirms this impression.¹ According to their survey of 100 randomly selected general surgeons, the decision to offer an outpatient appointment depended largely on the consultant's view of outpatient visits in general. The bimodal distribution of responses showed that some surgeons offered appointments to almost all their patients, irrespective of diagnosis or procedure, while others followed up almost none.

In keeping with this observation, a recent review of individual urological services in the South West Thames area of London showed that from 1991 to 1994, urological provider units were remarkably consistent in the ratio of new patients to follow up patients seen in their clinics.² However, there was substantial variation between providers. A ratio of one new to one follow up patient in one unit contrasted with a ratio of 1:4.9 at another, despite the two hospitals being only six kilometres apart and serving similar communities.

How is it that surgeons are able to adopt this all or nothing approach with regard to outpatient review? One way of justifying such behaviour is to suggest that routine surgical outpatient review is an unnecessary luxury, otherwise half the

See p 1344