We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

MARK THOMAS

MTAS

Mental health of applicants seems to be deteriorating

We are surveying the impact of Modernising Medical Careers (MMC) and the Medical Training Application Service (MTAS) on the mental wellbeing of junior doctors.[1] The preliminary results from the 790 online anonymous responses to date are disturbing and require an urgent response.

Overall, 395 (50%) respondents were women, 636 (80%) held UK/EEA passports, and 527 (67%) were aged 25-29.

Most worryingly, 165 (21%; 95% confidence interval 18% to 24%) respondents agreed or strongly agreed with the statement: "I have been having more thoughts of ending my life than usual"—an increased level of suicidal risk in an already vulnerable professional group.[2]

Most trainees (740, 94%) admitted to higher than usual stress levels over the past six months, 759 (96%) attributing it to MTAS/MMC compared with 411 (52%) attributing it to financial problems.

Respondents agreed, or strongly agreed, with disturbances in their sleep (523, 66%), appetite (330, 42%), and energy levels (571, 72%). A large proportion agreed to experiencing anhedonia (526, 67%), less enjoyment of sex (352, 45%), tearfulness (508, 64%), irritability (699, 88%), and a sense of future hopelessness (402, 51%). They also reported physical (399, 51%) and psychological (679, 86%) anxiety symptoms. Considerable numbers admitted to increased consumption of alcohol (279, 35%) but not recreational drugs (20, 2.5%).

The results also imply that the past six months might have had a negative impact on patient care. Compared with their usual clinical practice, 240 (30%) admitted that they made more mistakes at work, 342 (43%) that they cared less about patient care, and 673 (85%) that they enjoyed work less. In addition, 177 (22%) had taken more sick leave than usual. But only 64 (8.1%) had sought professional help for their difficulties.

The Royal College of Psychiatrists has set up support mechanisms for affected psychiatric trainees. It will present the findings of the completed survey to all the medical royal colleges so that they can consider establishing appropriate support mechanisms for trainees in their specialty. The college also intends to explore the regular monitoring of the mental health of junior doctors.

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Competing interests: None declared.

1 Godlee F. The future of specialist training. *BMJ* 2007;334:1067-8. (26 May.)
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COSMETIC GENITOPLASTY

It's female genital mutilation and should be prosecuted

Liao and Creighton ask how healthcare providers in the United Kingdom should respond to requests for "genitoplasty,"[1] or what two UK websites call "labial reduction" and "female genital reshaping."[2 3] This procedure, which entails "the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons,"[4] is a criminal offence in the UK under the Female Genital Mutilation Act.[4 5]

Notes to the act say that no offence has been committed if the surgery is necessary for the woman's physical or mental health—for example, in cases of cancer, gender reassignment surgery, or "distress caused by a perception of abnormality."[5] The *BMJ* article focuses on the latter. The women interviewed who had this surgery were "anxious" because they had been led to believe—for example, by advertisements for cosmetic surgery—that their labia were too large, uneven, or unshapely. Their reasons were without exception non-therapeutic.

The contradictions are blatant. If a woman (probably African) asks for her own or her daughter's genitals to be excised for traditional reasons, it is refused as a criminal offence. Yet if a woman thinks her own genitals are an abnormal shape or size, the surgery is provided. The Department of Health is lending legitimacy to this on its website giving advice on cosmetic surgery.[2] Yet the Department for International Development supports efforts to combat female genital mutilation in other countries.

Surgery is rarely an answer to psychological problems. This surgery is exploiting women's lack of bodily self esteem. No one is offering to shorten or lengthen men's penises or change the shape or size of their testicles for "cosmetic" reasons. There is no evidence of any benefit of this surgery for mental health, but ample evidence of its potential and actual harm. The law against female genital mutilation must be enforced.

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3 BUPA Hospitals. *Cosmetic surgery*. www.bupahospitals.co.uk/asp/cosmetic/women/body_reshaping/labial_reduction.asp
4 Female Genital Mutilation Act 2003. www.opsi.gov.uk/acts/acts2003/20030031.htm#1
5 Female Genital Mutilation (Scotland) Act 2005. www.opsi.gov.uk/legislation/scotland/en2005/aspen_20050008_en.pdf

IMAGING PERIPHERAL DISEASE

Gadolinium contrast may be risky in kidney disease

Collins et al and the accompanying editorial conclude that contrast enhanced magnetic resonance angiography (MRA)

is a viable alternative to conventional contrast angiography for assessing patients with peripheral arterial disease before treatment.[1 2] The authors found an adverse event rate of up to 10% associated with contrast enhanced MRA, lower than other techniques and generally mild compared with conventional contrast angiography.

We draw attention to the association between the use of gadolinium based contrast agents for MRA and the development of nephrogenic systemic fibrosis,[3] a newly described chronic, debilitating disease characterised by progressive fibrosis of the skin, heart, lungs, and pleura with considerable morbidity and mortality. Development is predominately restricted to patients with stage V chronic kidney disease (estimated glomerular filtration rate less than 15 ml/min) and in those with acute renal failure, especially with liver failure. Most cases have been associated with the use of gadodiamide (Omniscan), some with gadopentate dimeglumine (Magnevist), and a few with gadoversetamide (Optimark)—all linear gadolinium chelates.

We found nephrogenic systemic fibrosis in 3.1% of patients receiving renal replacement therapy in Glasgow exposed to gadodiamide[4]—a similar finding to that of other groups[5]—and a dose dependent relation.

Many patients with peripheral vascular disease will have concurrent kidney disease, and the small yet clinically significant risk of developing nephrogenic systemic fibrosis should be considered when deciding whether to proceed with contrast enhanced MRA in patients with advanced kidney disease.

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WHAT ABOUT THE GPs?

We help treat acute coronary syndromes

I was disappointed that the role of primary care and cardiac rehabilitation in the long term treatment of patients with acute coronary syndromes was not acknowledged by Peters et al.[1] A similar review in the *Lancet* made the same omission.[2] The importance of cardiac rehabilitation after myocardial infarction has recently been emphasised by guidance from the National Institute for Health and Clinical Excellence.[3] The evidence for the effectiveness of nurse led secondary prevention clinics for coronary heart disease in primary care[4] has been included in the quality and outcomes framework of the new general practitioner contract. When such primary care based clinics are integrated with cardiac rehabilitation programmes, optimal longterm treatment is possible for patients with acute coronary syndromes.[5]

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We're still great for continuity

I was saddened, but not surprised, to see no mention of primary care in the editorial on transition of care in children with chronic disease.[1] In the United Kingdom, young people with chronic diseases are likely to have a general practitioner. Over the course of their life that doctor will have received numerous letters about their care and plans. These can be, and should be, educational. When dedicated paediatric care is no longer needed, adult expert clinics are needed, but so are day to day care and acute management of disease complications. Although the current organisation, after the new contract, of general practitioner care is less easy to navigate for patients, there should be a familiar face of someone who knows this group of patients and their illness.

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NHS INDEPENDENCE

An NHS board is the way forward

The reports on removing the NHS from direct government control are heartening.[1-3] There is, however, an option that gives the NHS its independence and removes the hegemony of one political party. Balancing political input[4] into an NHS corporation that fully manages the NHS as described by Edwards[3] will satisfy critics who complain that we can never remove politics from the NHS and that we need politicians to drive the change. The board should have MPs representing the main political parties, in addition to elected members from health professionals, trade unions, managers, and patient groups. One member one vote with two third majority decisions will ensure that no one party will ever again run the NHS with an eye on the next election—an electoral college as described by Edwards with one difference: members are democratically elected from their organisations rather than nominated by ministers.

Such a model would be ideal for Wales as it currently does not have foundation trusts or large scale privatisations. Since the May assembly election it has had a minority Labour government seeking coalition with the Liberal Democrats one day and Plaid Cymru the next, without yet settling on a solution—so, why not an all party NHS board?

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