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Getting men into medicine

Men are finding it increasingly difficult to access a medical career. The current admissions criteria to gain entry to UK medical schools have resulted in more women being accepted than in the past. The situation is similar to 50 years ago, but in reverse, when women found it difficult to obtain a place to train in medicine. Fortunately this under-representation of females has gradually been rectified but now the pendulum has swung the other way. This has resulted in a profession which in future will be deprived of the contribution of men. Patients will find it difficult to see a male GP if they so wish. As the population is composed of approximately equal numbers of males and females would it not be sensible to reflect this in our medical workforce and provide a degree of balance?

According to the Centre for Workforce Intelligence (CfWI) there may not be sufficient numbers in the GP workforce until 2030.¹ This is a worrying situation for both patients and doctors and is partially due to the fewer hours worked by women compared to men. As the current generation of male GPs retires, gaps will be exposed in service provision. By addressing the under-representation of men entering medical school the problem could be ameliorated, as historically men have tended to work longer hours than women and there is no evidence that this is going to change. Perhaps medical schools could review their admissions criteria, which currently favour those who are academically successful in school, and put greater emphasis on other qualities that contribute to the making of 'a good doctor' such as a caring and compassionate nature combined with emotional and physical resilience. Admissions tutors must be aware that boys mature later than girls and the necessary qualities required may not be so evident at age 18 in the male sex. Maybe this later flowering of abilities needs to be given greater recognition during the selection process to help improve this area of developing inequality in the medical workforce.

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REFERENCE

1. Centre for Workforce Intelligence. *GP in-depth review. Preliminary findings*. <http://www.cfwi.org.uk/publications/gp-in-depth-review-preliminary-findings/attachment.pdf> (accessed 27 Feb 2014).

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Top dietary iron sources in the UK

Iron deficiency carries substantial risks, including anaemia and transfusional requirements; suboptimal immune, skeletal muscle, and thyroid function; prematurity; poor maternal and perinatal outcomes in pregnancy; and impaired motor and cognitive development in children.¹ The reference nutrient intake (RNI) for iron is 8.7 mg/day for men and postmenopausal women, and 14.8 mg/day for premenopausal women,² but half of all women in the UK do not consume the 8.7 mg/day RNI.³ Iron requirements are higher still in pregnancy, and following non-menstrual 'haemorrhagic' losses such as blood donation, peripartum, gastrointestinal haemorrhage, surgery, and epistaxis.⁴ Although the proportion of dietary iron absorbed increases in iron deficiency, the degree of compensation for dietary shortfalls is not known.

To assist in advising patients with high iron requirements (patients with frequent epistaxis due to hereditary haemorrhagic telangiectasia), we used gold standard, prospective 7-day weighed food diaries to determine predominant dietary sources of iron in a real-life setting in the UK. We believe

the results will be generally informative for medical practitioners.

The high proportions of dietary iron contributed by fortified cereals and breads were remarkable, particularly as these are not currently listed as good iron sources by NHS Choices,⁵ and were not recognised as such by the study cohort. Participants could consume 87% of the RNI for men and/or postmenopausal women, and 51.4% of the RNI for premenopausal women, through breakfast cereals alone. Iron intake was higher from boxed, fortified cereals (87% maximal contribution to male RNI) than from porridge (5.5% maximal contribution to male RNI). Participants could also consume 51% of the RNI for men and/or postmenopausal women through bread, which included iron-fortified white breads as well as wholewheat. Dedicated vegetarian meals provided similar proportions of dietary iron to red meat. Eggs, fish, and other vegetables (especially potatoes, beans, and lentils) also provided high individual contributions. Conversely, large volumes of inhibitors of dietary iron absorption were ingested, particularly polyphenol-containing tea (average 829 mls/day) and coffee (155 mls/day). Nelson and Poulter⁶ advise that to enhance iron absorption, tea should be avoided 1 hour after an iron rich meal because 150 ml reduces non-haem iron absorption by 60–80%.

These data provide an easy route to identify individuals at risk of iron deficiency, and simple advice to address, particularly suggesting a bowl (or extra bowl) of their favourite iron-fortified breakfast cereals, and reducing tea and coffee intake with meals. The data may also help patients with iron overload states aiming to reduce dietary iron intake.

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