

Gender – or do we mean sex?

The use of language when dealing with gender and sex is important: the choice ranges from deliberately political and incendiary, to confusing despite the best of intentions.

The most recent issue of the *BJGP*¹ illustrates this amply. I was excited to see an issue devoted to 'Gender', as an associate in training (AiT) feeling the absence of education in gender medicine. It became increasingly clear that much of the issue was about sex-based topics – important and interesting, but conflated with a more nebulous (and largely undefined) concept of 'gender'.

Kath Checkland² describes the author of *Hags*, 'highlight[ing] the dangers to women of current attempts to downgrade the importance of biological sex', which is especially pertinent to the paper by Jefferson *et al.*³ Here, 'the authors relied on self-identification' (as well as other clues such as name) when it came to documenting uncertain gender, which they then appear to equate to sex. The distinction between sex and self-identified gender is of course vital to drawing any conclusions about discrimination; biology and gender incongruence may impact this, but for entirely different reasons.

The linguistic confusion continues in the 'gender' space. Brown *et al.*⁴ specifically acknowledge difficulties with conducting research because of coding complications and state the 'intention to balance inclusivity and specificity'; even they slip from 'transmasculine' and 'transfeminine', to 'transgender men' in the discussion – are such men in the former or latter category?

The difficulties with language are not specific to general practice, or to this journal. The laudable aim to make language inclusive may result in health-related harms⁵ such as confusion for non-English speakers or for those with learning difficulties – confusion experienced by Hannah Milton⁶ in this issue.

As Bewley *et al* have previously argued elsewhere: 'Ambiguous data collection methods that conflate sex and gender risk erroneous research findings, poor service planning, and lower quality medical practice.'⁷ And this extends to discussing sex-based experience of all kinds, whether it is discrimination, health care, or cultural experience.

So a plea to the *BJGP* to highlight the need for clarity in sex and gender, not to add to the confusion.

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A system to enable the early detection of new side effects of recently marketed drugs

The system would work as follows: when a patient taking a recently marketed drug develops a symptom, the symptom is entered on the computer in the usual way. If the Medicines and Healthcare products Regulatory Agency (MHRA) has already received a report/reports of the same symptom experienced by a patient taking the newly marketed drug, an alert would appear on the screen saying 'this is a suspected side effect of the newly marketed drug A. Please click on the link to report this suspected side effect to the MHRA.'

The MHRA would simultaneously extract from the patient's record their current medication and other relevant patient data, all in an anonymised form. This way, new

and possibly dangerous side effects of recently marketed drugs could be detected at an early stage.

To my knowledge, such a system does not currently exist. If this facility was rolled out worldwide, even earlier detection of new side effects of recently marketed drugs could be achieved.

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Competing interests

David Orlans retired from general practice over 11 years ago. Many years ago he passed on his ideas to a medical informatics company on a no-personal-profit basis.

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Correction

Mapping GPs' motivation – it's not all about the money: a nationwide cross-sectional survey study from Denmark. Yordanov D, Oxholm AS, Gyrd-Hansen D, Pedersen LB. *Br J Gen Pract* 2023; DOI: <https://doi.org/10.3399/BJGP.2022.0563>. The title of this article has been revised and in Figure 2, the barcharts for Class 5 have been corrected so they are no longer floating above the x axis.

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