

their circumstances to provide the continuity.

My next point concerns general practice as the integrating discipline. I read with interest the six special opportunities to integrate care in general practice. While the author emphasises the importance of getting to know the patient, their experiences, and their hopes and fears as an essential part of continuity, nowhere is it suggested that representatives of patients should be a central part of integrated care. Surely in 2023 that is essential for the present and the future. Such stated involvement of including patient representatives as the seventh special opportunity to integrate care in general practice would really strengthen the GP case as the integrated specialism as well as setting an example to all specialities.

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## No, we mean sex AND gender

The use of language when dealing with gender and sex is important: in the field of health inequalities, it is important to recognise these two factors and how they interact in patients' health and outcomes.

While sex is important for considerations of disease and genetic or biological risk, gender carries importance in the aspect of behaviours, systemic barriers to health care, and social determinants of health inequality. To acknowledge one does not devalue the other. To ignore gender or see it as synonymous with sex is to arrive at biological determinism that does not accurately describe public health or patient experience. Worse yet, to attempt to politicise inclusive healthcare<sup>1</sup> serves no one.

In our paper,<sup>2</sup> we described our participants as transmasculine and transfeminine based on their gender-affirming therapy. This avoided assumptions about their gender identity as this information is not available in the medical record. To assume every transgender person taking testosterone identifies as male ignores the potential for

non-binary people to be in our data. Other researchers' methods, data, or language have differed from ours, and it is our duty to cite them correctly, leading to the use of both 'trans man' and 'transmasculine' in our paper.

Those who do conflate sex and gender in medical research are unfortunately reinforced by the clinical systems on which we rely. In the GP patient record, sex and gender exist under one marker. We need only look to the NHS's process for re-registering gender as a testament to this limitation and how it can lead to multiple systemic errors in access to screening and diagnostics for transgender patients. Having two distinct 'sex registered at birth' and 'gender' markers would facilitate greater accuracy in systems, patient care, and future research.

To praise the aim of inclusive language but then disparage it by weaponising other minoritised communities against its application is unfortunate. An intersectional view recognises that those who have English as a second language and those with learning disabilities can also be LGBT+. To ignore this is an oversight.

While it is disappointing to see people overlook the finding that transgender people in the UK have a higher prevalence of cancer risk factors in favour of criticising the terms used by and for the community, we cannot say this is uncommon in this current climate.

Our hope is that our esteemed colleagues, with all of their experience in understanding complex theory, can appreciate the relationship between sex and gender, and how it is appropriate and necessary to explore their relationship to each other when investigating transgender community mortality.

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## Judgement of data saturation

I read the article by Jones *et al*<sup>1</sup> with great interest and strongly appreciate the importance of this study. The research question sheds light on the unique and indispensable role of GPs. The research topic, which focuses on dementia prevention and the GP's role, is expected to encompass a wide range of relevant themes.

The authors mention that data saturation was achieved by interviewing 11 participants for an average of 26 minutes each. In the broader context, data saturation refers to the point in data collection where no additional insights are identified, and further data collection becomes redundant. Given the depth and breadth of the area covered by this research topic, it is challenging to imagine data saturation being reached in short-term interviews with a relatively small number of participants.

Two possible factors may have influenced the judgement of data saturation in this study. First, the participants might be from a homogeneous and small community. Hennink and Kaiser<sup>2</sup> suggest that saturation may be reached within a few interviews (typically between nine to 17) when participants belong to relatively homogeneous populations with narrowly defined objectives. As a reader of the article, I am curious about the participants, but the authors did not provide detailed information about them, only stating that they recruited participants via convenience sampling from existing networks in the UK. It raises suspicion that the participants might be from a specific small and homogeneous population, which could explain why no novel opinions were collected.

Second, although there is no gold standard to confirm whether data saturation is reached, the authors' procedure appears to be relatively basic. Guest *et al*<sup>3</sup> propose that data saturation consists of three distinct elements: the base size, the run length, and the new information threshold. They suggest a straightforward yet more robust method to