

Letters

Exclusionary language has no place in *AJGP*

Thank you for publishing the article 'General practitioner disaster support for pregnant women, new mothers, infants and young children: Findings from the Babies and Young Children in the Black Summer (BiBS) study' by Hamrosi and Gribble (*AJGP* Jan-Feb 2025). The article provides valuable insights into disaster support for parents and young children. However, we would like to express concerns regarding its language and the implications for patients and clinicians.

Academic and clinical discussions about parenting, birth and infant care should be guided by both scientific evidence and inclusivity. While the article asserts that these experiences require a binary gender approach, its own language primarily refers to 'caregivers' and 'parents' without substantiating a strictly binary classification. Additionally, there is no indication in the method that gender data were collected from participants, making the assumption of binary gender roles problematic from both methodological and ethical perspectives. The definition of women as 'adult female people' within the article raises concerns about its intent and implications. Attempts to strictly define women are widely recognised as organised trans-exclusionary rhetoric¹ and contribute to the marginalisation of transgender and non-binary parents. Parenting, infant care and breastfeeding as the domain of two binary genders is by no means a settled issue.² Given the well-documented barriers that lesbian, gay, bisexual, transgender, queer, intersex, asexual and other (LGBTQIA+) individuals face in healthcare^{3,4} – barriers that likely extend to disaster-response settings – we question whether such language serves an

evidence-based purpose or instead fosters exclusion and harm.

Beyond the impact on patients, we are also deeply concerned about the message this sends to gender-diverse clinicians and the wider LGBTQIA+ medical community. The Royal Australian College of General Practitioners (RACGP) has a responsibility to create a professional environment where all general practitioners feel valued and respected. Endorsing language that has been used to exclude and stigmatise transgender and non-binary individuals risks alienating LGBTQIA+ doctors, trainees and medical students.⁵ As a journal representing the RACGP, *AJGP* plays a critical role in fostering evidence-based, respectful and inclusive discussions within the medical community. The College must take care not to provide implicit support for language and narratives that exclude or stigmatise already vulnerable groups.

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Reply: Exclusionary language has no place in *AJGP*

We would like to thank Drs Riley, Predny and Dorrington for their letter. We acknowledge that, with increasing cultural salience of the concept of gender identity, more individuals are expressing a gender identity that differs from their sex. Some advocates therefore request that terms directly referring to sex, such as 'women' and 'mothers', be avoided.

In regard to our research, we recruited 'parents' and 'caregivers' for our study; however, we found a clear sex-based difference in experience between mothers and fathers. We thus referred to 'women' and 'mothers' where relevant. When we asked study participants about their gender identity, none indicated any sex–gender identity discordance. However, several indicated gender identity was a concept not applicable to them. We reject the notion that the long-established (>1500 years)

definition of women as ‘adult female people’¹ is problematic, especially in a medical journal.

We agree that in providing individual healthcare, it is essential to use language aligning with each person’s preference. We acknowledge the rich diversity of parents and caregivers across race, religion, culture, education, disability, health, socioeconomic, sexuality, gender identity and family constellations. Appropriate language to ensure individuals feel safe, respected and welcome will vary. For gender-diverse people, this may include avoiding references to sex wherever possible. However, it should be recognised that documenting the sex of all patients remains important. Misrecording and/or misreporting of sex has resulted in serious harm.² Hospitals in a number of jurisdictions have instituted policies ensuring accurate recording of sex for reasons of patient safety and data integrity.³ General practitioners have a role in patient education in regard to this.

In public health communication and policy, there are numerous examples of confusion and other unintended consequences of avoiding sex-specific language. Research is needed to properly assess the extent and context of these impacts and to explore how they might be mitigated.⁴ We recognise the language challenges in this space, which have important implications for general practice. We welcome robust discussion and the development of policies that provide guidance on language use and resources for those with specific language needs.

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The COVID-19 pandemic highlighted trainee burnout – as time passes, we cannot lose sight of this issue

The COVID-19 pandemic has been a highly stressful period for many doctors, particularly those on the front lines of care. Working in a rapidly evolving clinical and administrative landscape, the pandemic served to shine a spotlight on burnout in medicine. Indeed, in a recent systematic review and meta-analysis, we identified that the volume of literature examining burnout in postgraduate medical trainees more than doubled during the pandemic.¹ Within that review, we ran a subgroup analysis specifically focusing on general practice trainees and found no significant differences in their burnout scores during the pandemic. We argue that these seemingly counterintuitive results are understandable by the simple fact that they mask the burnout reported by this group *before* the pandemic. The same subgroup analyses demonstrate that general practice trainees’ depersonalisation (indicative of severe burnout)² was elevated prior to the pandemic. Further, although there was not a significant elevation in these trainees’ emotional exhaustion scores, during the pandemic, general practice trainees’ emotional exhaustion was significantly elevated when compared with normative data.¹ Concerns regarding burnout in medical trainees long predate the onset of the COVID-19 pandemic.³ One positive side effect of the pandemic has been the increased attention on this issue, as evidenced by the literature on this topic doubling in the past five years. However, it therefore stands to reason that trainee burnout will long endure after the pandemic subsides. The risk we face is that the spotlight shifts away from trainee burnout. We encourage these findings to demonstrate the critical need to avoid

this mistake; supporting the wellbeing of our trainees is essential for a sustainable, thriving medicine and, as such, a sustainable, thriving society.

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Erratum

Patel S. Ferric carboxymaltose: A practical guide on the administration of iron infusions in general practice. *Aust J Gen Pract* 2025;54(5):287–94. Available at www1.racgp.org.au/ajgp/2025/may/ferric-carboxymaltose-a-practical-guide-on-the-adm

In this article, the following sentence is incorrect: ‘Although iron derisomaltose is argued to have a lower risk of hypophosphataemia, the overall side effect profile is argued to be higher.’^a

It should have read: ‘Iron derisomaltose has been argued to have a lower risk of hypophosphataemia.’^a

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