sense is precisely what has eroded the trust of our patients and opened us up to justifiable claims of professional arrogance in dismissing alternative approaches to health care. Nobody is arguing that these are not more effective when applied at a population health level, but this should not preclude GPs from applying our professional common sense in tailoring sensible and safe lifestyle interventions for our patients.

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The academic triad in general practice

Reilly *et al*'s article on GP scholarship[1] is important and we warmly support it. They rightly state that academic general practice should be *'integrated and accessible to grass roots GPs'*. Secondary care has long had its teaching hospitals and long trumpeted the academic triad of good service for patients, teaching, and research all in the same place. GPs should seek to replicate this triad.

We report that our practice obtained the Investors in People award and has been twice rated outstanding by the Care Quality Commission. For educational development, since 1987, seven different GP managing partners have received higher university degrees. A nurse practitioner and an attached midwife obtained master's degrees and an attached district nurse a BSc. A medical student won the Quintiles prize for women in science while at the practice. In a typical year, over 40 medical students receive teaching in the practice.

There is a designated research room for research designed and conducted within the practice, and for 10 years running the practice has employed three successive postdoctoral research fellows. There have been 22 practice-based publications in peer-reviewed medical journals, as well as four in educational and policy publications, in the last 5 years. Our systematic review[2] of continuity of doctor care and mortality, in *BMJ Open* in 2018, was designed and conducted entirely within the practice, involved two medical students as co-authors, and has an Altmetric score of 2421, with 250 citations and over 87 000 downloads.

We offer this example as evidence that the academic triad can be built in general practice. NHS GP care, the teaching of medical and postgraduate students, and active research can all occur simultaneously in a single general practice. What is needed now is what teaching hospitals have had since 1948 — public recognition and reasonable financial support. Both the Royal College of General Practitioners and the Department of Health have responsibilities to ensure a level playing-field for general practice.

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Behavioural determinants of health: individual versus societal responsibility

Nunan *et al* draw our attention to the emphasis of so-called 'lifestyle medicine' on behavioural determinants of health and the responsibility of individuals for behaviour modification.[1] While it is important to address the leading behavioural determinants of premature mortality in England, namely tobacco use/unhealthy diet/alcohol and drug use/physical inactivity,[2] the authors rightly highlight the importance of considering the wider determinants of health.

An important point being made here is that overemphasis on health behaviours and individual-focused interventions (intentional or unintentional) may actually increase health inequalities and draw attention away from the main drivers of poor health, namely the wider socioeconomic and environmental determinants of health. As the Marmot reviews have shown us, differences in socioeconomic status are associated with dramatic differences in rates of premature mortality and disability; the 2020 review reported a 12-year difference in healthy life expectancy at birth between the most and least deprived regions of England.[3] Moreover, a recent cross-sectional study of 2.5 million premature deaths in England found that one-third of these deaths were attributable to socioeconomic inequality.[4]

Clearly, a balance must be struck between individual responsibility and wider societal/governmental responsibility. It is important not to minimise individual responsibility for one's own health or create a false dichotomy between individual responsibility and societal responsibility; both are important and should be advocated for simultaneously. Nunan *et al* provide a useful framework regarding ways to integrate 'individual-level interventions' with 'public health interventions' to address key modifiable risk factors. In doing so, the authors remind us of the importance of national policy in improving the nation's health and reducing health inequalities, by placing some of the responsibility at the feet of governments and national public health organisations.

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Are female authors under-represented in primary healthcare and general internal medicine journals?

Gender inequalities persist on a large scale in academic medicine. Compared with their male counterparts, female researchers generally receive lower salaries[1,2] and less funding for their studies.[3] They also have slower career progression.[4] The representation of female and male authorship is a simple measure and is a surrogate marker that reflects the level of gender gap in research.

We selected all interventional and observational studies and all reviews published in 2016–2020 in all primary healthcare (PHC) journals with a JCR 2019–2020 impact factor >1 (N = 16 journals) and in the same number of high-impact general internal medicine (GIM) journals. We then used Gender API (https://genderapi.io/) to determine the gender of the first authors. Finally, we calculated the proportion of articles authored by female researchers and compared the data by year of publication and by medical discipline using logistic regression adjusted for intra-cluster correlations (journal).

We retrieved 13 440 articles, the names of the authors being available for 13 329 of them. First authors' gender could be determined for 13 173 articles (98.8%). The proportion of female first authors ranged from 47.7% to 71.6% in PHC and from 24.3% to 53.3% in GIM. It was <50% in only one of 16 PHC journals and >50% in only one of 16 GIM journals. The difference between the two journal groups was statistically significant (53.7% for PHC versus 41.2% for GIM, adjusted odds ratio [AOR] = 1.66 [95% CI = 1.03 to 2.66], P-value = 0.04). The proportion of female first authors varied only slightly during the period under review (2020 compared with 2016: AOR = 0.98 [95% CI = 0.79 to 1.20], P-value = 0.81 for PHC, and AOR = 0.99 [95% CI = 0.90 to 1.09], P-value = 0.77 for GIM).

These results can be explained in part by a higher proportion of women in leadership positions in PHC compared with other medical disciplines.[5] They highlight the important contribution of female scholars to scientific knowledge in PHC.

Our study has two main limitations. First, gender assignment relied on a gender detection tool and not on self-determination, and the risk of misclassification was therefore not excluded. However, Gender API was shown to be very accurate.[6] Second, gender determination on the basis of first names raises ethical considerations by simplifying the concept of gender.[7]

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Corrections

In the editorial by Gerada C, General practice in crisis: stop skinning the cat. *Br J Gen Pract* 2021; DOI: https:// doi.org/10.3399/bjgp21X716153, there was an omission from the competing interests paragraph, so text should read: *'... ; board member and founder of eConsult; and independent advisor to Cygnet Health Care Advisory Board.'* The online version has been corrected.

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In the research by Berner AM, *et al*, Attitudes of transgender men and non-binary people to cervical screening: a cross-sectional mixed-methods study in the UK. *Br J Gen Pract* 2021; DOI: https://doi.org/10.3399/BJGP.2020.0905, the authors would like to clarify that the estimate that transgender people make up 0.3% and 1.2% of the population is derived from a number of epidemiological studies in different countries, and estimates may vary according to rate of disclosure in that country. The latter UK estimate is drawn from data from the Office for National Statistics. Therefore the estimates for percentages and absolute numbers may not directly reflect each other. Text in the introduction, second paragraph, last sentence, now reads: *'... trans people make up between 0.3% and 1.2% of the worldwide population.[11–16] An estimated 200 000–500 000 trans people live in the UK.[17]'* The online version has been corrected.

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