Fostering Gender-IQ: Barriers and enablers to gender-affirming behavior amongst an Australian general practitioner cohort

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Abstract:	Whilst the visible population of trans and gender diverse Australians has grown significantly in recent years, primary healthcare access remains hindered by a lack of practitioner competency and stigmatization. This article draws on qualitative research of purposively selected gender-affirming general practitioners (GPs) in Australia to explore barriers, and enablers when treating trans and gender diverse patients. Perspectives and behaviors during the gender-affirming clinical encounter were theoretically informed through minority stress theory, and master narrative frameworks. Reflexive thematic analysis facilitated a rich description of exemplary gender-affirming primary care. A considerable gap exists between structural, clinical, and cultural behaviors among competent gender-affirming GPs in Australia, and the majority of practitioners evidenced in the literature. This critical analysis contributes to better understanding how gender-affirming Australian GPs diffuse minority stress, negotiate cis-normative biases, and foster a person-centered longitudinal therapeutic relationship with their trans and gender diverse patients. An encounter the article argues may also provide an essential buffer for GPs in Australia against the risk of professional burnout. Gender-affirming practice should be taught as a core competency and be required as professional development for GPs in Australia, to ensure a beneficial clinical encounter for the growing trans and gender diverse population.

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Whilst the visible population of trans and gender diverse Australians has grown significantly in recent years, primary healthcare access remains hindered by a lack of practitioner competency and stigmatization. This article draws on qualitative research of purposively selected gender-affirming general practitioners (GPs) in Australia to explore barriers, and enablers when treating trans and gender diverse patients. Perspectives and behaviors during the gender-affirming clinical encounter were theoretically informed through minority stress theory, and master narrative frameworks. Reflexive thematic analysis facilitated a rich description of exemplary gender-affirming primary care. A considerable gap exists between structural, clinical, and cultural behaviors among competent gender-affirming GPs in Australia, and the majority of practitioners evidenced in the literature. This critical analysis contributes to better understanding how gender-affirming Australian GPs diffuse minority stress, negotiate cis-normative biases, and foster a person-centered longitudinal therapeutic relationship with their trans and gender diverse patients. An encounter the article argues may also provide an essential buffer for GPs in Australia against the risk of professional burnout. Gender-affirming practice should be taught as a core competency and be required as professional development for GPs in Australia, to ensure a beneficial clinical encounter for the growing trans and gender diverse population.

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Introduction

Whilst there is considerable evidence of a significant and continuing increase in the number of trans and gender diverse individuals seeking primary care support in Australia, literature with a specific focus on general practitioner (GP; i.e., physicians in primary care) perspectives of trans and gender diverse primary care provision remains scarce (Cheung et al., 2018; Heng et al., 2019). The past decade has seen moves to institutionally de-pathologize gender identity both in the *Diagnostic and Statistical*

Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association (APA), 2013) and the *International Statistical Classification of Diseases and Related Health Problems* (11th ed.; ICD-11; World Health Organization (WHO), 2019). However, despite progressive initiatives such as the informed consent model for hormone prescription, trans and gender diverse patients continue to experience non-affirming primary care through structural stigma, provider ignorance, and cultural competency deficit (Shepherd & Hanckel, 2021). In contrast, trans and gender diverse population mental health has been shown to benefit from access to gender-affirming and supportive primary care (Kattari et al., 2020). Initiatives posited to improve the trans and gender diverse primary care encounter include: systemic progress to address structural stigma, clinical training and professional development for GPs, as well as cultural competency in records keeping and patient gendering (Strauss, Winter, et al., 2020).

As trans health scholars, allies and clinicians, including trans people with lived experience of gender-affirming processes within the research team, we are concerned with the paucity of reporting on how to best deliver holistic, person-centered, and gender-affirming primary care from the GPs themselves. With a specific focus on narratives from recognized gender-affirming GPs, this article reports on research that sought to redress the deficiency through qualitative enquiry of the research question: "What are the barriers and enablers for gender-affirming behavior amongst an Australian GP cohort?" Establishing a construct of what gender-affirming primary care can look like, this paper sets out to describe the behaviors Australian primary care providers should be competent to model through essential medical school training and ongoing professional development. The paper is presented in several sections beginning with a review of contemporary literature relevant to Australian trans and gender diverse

primary care. The intersection of theoretical frameworks in the trans and gender diverse clinical encounter is then explored, followed by methodology and method for qualitative enquiry with an Australian GP cohort. Finally, the study results, discussion and conclusions are presented.

Trans and Gender Diverse Medicalization and Demography

Gender diversity as a valid and continuing construct from ancient times, across multiple cultural settings, is firmly established within contemporary Indigenous cultures such as the *Sistergirls* and *Brotherboys* amongst First Nation Australians (Kerry, 2014). However, from the beginnings of modern psychological practice in the late 19th century gender diversity was conflated with homosexuality and considered a deviant behavior in need of a cure (Shepherd & Hanckel, 2021). Gender identity was finally recognized as a discrete construct in 1968 (Fiani & Han, 2019) and pathologized as transsexualism and gender identity disorder of childhood, in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; DSM-3; APA, 1980). As a mental health disorder, resolution of gender diversity was through transition from one binary gender representation to the binary other (Newman et al., 2021).

It was not until 2010 that the World Professional Association of Transgender Health (WPATH) formally addressed the pathological and binary perspective of gender diversity in their *Standards of Care* (7th ed.; SOC-7) with "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative" (2011, p. 4). A normative shift supported by publication of DSM-5 (APA, 2013), where gender dysphoria supplanted gender identity disorder (Davy & Toze, 2018), and ICD-11 (WHO, 2019) which specified a gender incongruence diagnosis. However, a continuing diagnostic

emphasis on both distress and incongruence perpetuated the perspective that expressions of gender variance were synonymous with mental illness, and thus vulnerable to stigmatization (Davy & Toze, 2018).

Australian trans and gender diverse adult healthcare provision is guided by the WPATH SOC-7 (2011), which exhorts health professionals to "assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves" (p. 1). How Australian GPs are empowered to support these pathways is unclear, with a maximum of five teaching hours, mostly addressing sexuality, reported within medical school curricula (Grant et al., 2020). An educational deficit identified by Snelgrove et al. (2012) as contributing to multiple affirming care barriers amongst practitioners including: knowledge deficits, ethical dilemmas, pathologizing of gender diversity, and systemic issues. Institutional inertia in the adoption of evolving perspectives of gender identity, and an absence of education and professional development for GPs, has left a competency gap in urgent need of redress (Heng et al., 2019). Contemporary literature continues to describe multifaceted challenges to the receipt of gender-affirming treatment including structural stigma, clinical knowledge deficit, and cultural barriers (Dolan et al., 2020; Shepherd & Hanckel, 2021).

Australian research documenting numbers of trans and gender diverse patients seeking endocrine support reinforces the perspective that a latent population is becoming increasingly visible, and engaging with the healthcare community (Cheung et al., 2018). A growth in cohort articulated by Zhang et al. (2020) in their systematic review, where careful expansion of gender diversity definitions to include greater expressive breadth, yielded an adult trans and gender diverse cohort of up to 4.5%, and child/adolescent trans and gender diverse prevalence as high as 8.4%. The emerging

visible trans and gender diverse population is both more diverse and younger than previously reported. Recent studies finding equity in trans-feminine and trans-masculine representation and an increasingly non-binary cohort as greater numbers of adolescent and young adult individuals identify as trans, one Australian study reporting non-binary individuals comprising 30% of the more youthful cohort (Cheung et al., 2018; Cheung et al., 2020; Delahunt et al., 2018).

Despite these growing numbers, trans and gender diverse people experience disproportionate negative social determinants of health including: unemployment, discrimination, economic hardship, and violence (Brömdal et al., 2019; Sanders et al., 2022; Zwickl et al., 2021). In Australia, Zwickl et al. (2021) documented a lifetime medically diagnosed depression rate of 85% within an adult trans and gender diverse sample, with 63% reporting self-harm, and 43% having attempted suicide. Strauss, Cook, et al. (2020) reported younger (14–25 years) trans and gender diverse Australians also experience a high degree of mental distress with diagnosis of depression (75%), and self-harm (80%). Strauss, Cook, et al. (2020) positing Australian trans and gender diverse depression diagnosis rates were seven times greater than the general adolescent population. The attempted suicide rate for the adolescent trans and gender diverse cohort was 48%, or over 14 times that of the general Australian adult population (Strauss, Cook, et al., 2020). An increasing body of research asserts trans and gender diverse mental health deficits are not primarily caused by gender identity per se, but rather are a response to institutional discrimination and stigma across multiple social domains including, vitally, access to gender-affirming healthcare (Hughto et al., 2022; Strauss, Cook, et al., 2020; Zwickl et al., 2021).

An evident lack of GP training and exposure in trans and gender diverse medical care often results in provision premised upon an anachronistic perspective of gender

diversity and structural gender binarism, that compromise accessibility for trans and gender diverse individuals (Grant et al., 2020; Kcomt, 2019; Newman et al., 2021). Such care provider ignorance leaves the strong potential for the presenting healthcare needs of trans and gender diverse patients to go unmet (Dolan et al., 2020; Newman et al., 2021). A scenario that can lead to the trans and gender diverse patient having to enact a reassuring, self-affirming, and frequently educational role during the consultation (Newman et al., 2021; Zwickl et al., 2019)

Theoretical Frameworks

This study primarily engages two intersecting frameworks to better understand the trans and gender diverse primary care encounter: *Minority Stress Theory*, and M*aster Narrative Frameworks*. Minority stress theory posits that discrimination directed towards a minority in society produces incremental and differentiated stressors (Meyer, 1995). Distal, or external stressors are experienced as observable, objective acts of non-affirmation including discrimination and rejection of trans and gender diverse identity (Hendricks & Testa, 2012). Internal, or proximal, stressors are more subjective in nature and include: anticipatory fear of further discrimination, chronic performance stress of identity concealment, and perhaps epitomized by internalized transphobia (Hendricks & Testa, 2012). During a non-affirming primary care encounter, minority stress theory predicts depleted coping skills negatively impacting therapeutic benefit for trans and gender diverse patients (Kolp et al., 2020).

In essence, a master narrative describes standards of validity for the majority which are internalized, and only visible when in negotiation. *Cis-normativity*, as a master narrative framework, is the shared cultural account of gender that informs: cognition, value systems, and behavior (McLean & Syed, 2015). The unstated ubiquity of cis-normativity position it as a defining master narrative of the primary care

encounter, situating trans and gender diverse identities as pathological and abnormal, and thus medically resolvable into a normative gender binary (Bradford & Sayed, 2019). Once exposed, master narratives serve to marginalize transgressors and are largely resistant to change (McLean & Syed, 2015). Thus, trans and gender diverse patients report primary care practitioners expressing rigid gender binary perspectives, and more prescriptive gender roles than those observed in society at large (Bradford & Syed, 2019).

Methodology and Method

The authors of this article comprise a research team collectively committed to documenting the structural, clinical, and cultural behaviors among competent gender-affirming Australian GPs, and exposing the deficit in trans and gender diverse primary care delivery by the majority of practitioners as evidenced in the literature. Our scholarship spans disciplines of gender and trans studies, sociology, clinical and health psychology and sexual health medicine. The authors have been intimately engaged in trans rights, health research and practice, and advocacy within and beyond the Australian primary care environment for four to 22 years, and collectively we have more than 61 years of experience in the field. Our authorship team includes researchers of trans and cisgender lived and embodied experiences spanning sexual orientations (pansexual, heterosexual, homosexual), and ethnic and cultural backgrounds (North African descent, White Australian, and White European descent). Importantly the lead author is a trans woman who in more than ten years of accessing Australian primary care across multiple settings, was consistently concerned by the lack of gender-affirming competency in the encounter.

In addressing the research question: “What are the barriers and enablers for gender-affirming behavior amongst an Australian GP cohort?” distinct theoretical

frameworks have been posited as complicit in adverse trans and gender diverse primary care encounters. A cis-normative master narrative framework influencing care provider behavior (Bradford & Syed, 2019), and minority stress impacting trans and gender diverse patient receptivity (Lefevor et al., 2019). Exploration of practitioner and patient interaction was conducted through an ontological lens of critical realism, acknowledging outcomes are theory-informed but not entirely theory-determined (Fletcher, 2016). A critical realist position facilitated exploration of gender-affirming primary care to describe an exemplar of intersecting structural, clinical, and cultural behaviors, that might suggest positive change (Braun & Clarke, 2013; Fletcher, 2016). The research utilized an epistemological assumption of contextualism, accepting no single reality in the trans and gender diverse primary care encounter, rather that affirming knowledge will emerge from the encounter's human context, and researcher positionality (Braun & Clarke, 2013; Tebes, 2005).

With an ontology underpinned by critical realism (Braun & Clarke, 2013), the construct of information power (Malterud et al., 2016), was utilized in planning and assessing participant sample size adequacy. A singular focus on the clinical encounter between the GP, and the trans or gender diverse patient kept the study aim narrow. In contrast to previous research (Snelgrove et al., 2012), participation required a dense specificity of gender-affirming experiences and knowledge across participants. The research leverages both a master narrative framework (Bradford & Syed, 2019), and minority stress theory to provide a strong theoretical background (Myer, 1995). Lead author positionality as partial insider, with intimate a priori knowledge, facilitated the production of strong interview dialogue. Finally, a case-based strategy was utilized, with deep analysis of purposively selected participant narratives (Malterud et al., 2016). Reflection on the information power items suggested a minimum viable sample size of

four, whilst recruitment readily generated seven participants, which repeated appraisal of information power indicated was sufficient (Malterud et al., 2016).

A focus on practicing gender-affirming GPs sought to mitigate a significant limitation identified by Snelgrove et al. (2012) in their research, finding a lack of trans and gender diverse exposure amongst participants essentially negated their ability to articulate specific barriers, or enablers to affirming care. Whilst not exclusionary, other recruitment criteria were: range of experience both as a GP and in gender-affirming care, urban or rural practice location, and practice orientation (i.e., family or LGBTIQ+ focus).

The opportunity for research into the challenges of gender-affirming primary care coincided with the formation of a voluntary professional support group, the Gender Affirming Network Queensland (GANQ) based in Brisbane. The stated ethos of GANQ is *nothing about us, without us* to deliberately platform trans inclusivity, with participation encouraged from healthcare disciplines engaged in gender-affirming care and community members. For the lead author partial insider status, whilst privileged, did present a challenge to objective perception and critical analysis through subjective involvement, potentially exposing the project to detrimental researcher biases (DeLyser, 2001). Mediation was sought through engagement of community participation within GANQ, specifically a trans and gender diverse retired GP, and gender diverse peer support from within the wider research team.

Participants were recruited through two avenues, directly through attendance at GANQ meetings, and by referral through Dr. XX as industry collaborator, specifically to obtain a regional Australian perspective not readily available at GANQ sessions. Of the participants, four identified as women and three as men. No participant identified as trans or gender diverse, although one participant did identify as the parent of a trans

child. Three participants identified as members of the lesbian, gay, bisexual community and one as the child of lesbian parents. Of the remaining two participants, one identified as a cis heterosexual man, and the other offered no explicit gender orientation. GP experience ranged from six to 42 years, and length of gender-affirming practice from six months to more than three decades. Six participants practiced in metropolitan and regional settings, with one participant situated in a rural Australian location. Central to ethics considerations for this project was confidentiality, the participants were situated in the public eye, drawn from a small and overlapping cohort, and exposed to the possibility of referencing sensitive and potentially identifying patient information. The project was subsequently approved by the authors' university ethics board – X Human Research Ethics Committee (CODE).

The semi-structured interview format was deemed appropriate for the study as it facilitated both a focus on issues that are meaningful for the participant and expression of their diverse perceptions (Cridland et al., 2015). Each interview was conducted by the lead author utilizing the project's interview guide, digitally recorded, and with a duration of 45-60 minutes (M = 55 minutes). Interviews were conducted during May and June 2021, five in person, with three at private premises and two at the participant's practice. The rest of the interviews (two) were conducted online via Zoom. Partial insider positioning proved beneficial throughout the interview process, facilitating a flexible power dynamic through several relationship dyads: GP and patient, participant and researcher, and cis-gender and trans person. Maintaining a critical realist/contextualized posture, and fluid power negotiations, enabled the lead author to draw on personal experience during interviews to validate, probe, and where appropriate elucidate. Extensive transcription, auditing, notating and anonymizing tasks, provided in-depth data familiarization through researcher immersion. Vitally, as a trans woman,

the lead author was able to interrogate the data with a perspective of *how* they would feel, were they situated as the patient in a participant encounter (Braun & Clarke, 2013).

Reflexive thematic analysis (RTA), as described by Braun and Clarke (2021) was selected as an effective method to analyze the complex and nuanced nature of trans and gender diverse primary care encounters. Braun and Clarke (2019) posit that RTA (comprehensively unpacked in Braun & Clarke 2013), whilst theoretically underpinned, positions the researcher as vital to the role of knowledge production working at the interface of analytic method, participant data, and subjectivity. The practice of bending back upon oneself, reflexivity, is essential to the process throughout, and requires the researcher to engage their own experiences, perspectives, and values across the research phases (Braun & Clarke, 2021). The RTA design for the project required participant data analysis at the latent level to examine underlying assumptions and concepts, with themes generated through worked interpretation of the theorized environment (Braun & Clarke, 2013).

In accord with theoretical RTA methodology, semantically descriptive codes were deductively pre-defined premised upon the project research question, existing theory, and researcher positionality (Braun & Clarke, 2013). Full data coding was performed, with initial coding reviewed, refined, and collated through an iterative and reflexive process. Candidate themes were then developed in accord with the central organising concept rationale described by Braun and Clarke (2013). Theme development and definition was again an iterative and reflexive process, incorporating lived embodied experiences, the body of literature, and of course the participant narratives, with a particular focus on the salience of latent, or abstract, messages in the dataset (Buetow, 2010). Rigor in code evolution and theme development was provided through iterative co-author review and oversight. The Braun and Clarke (2006) 15 step

checklist for good thematic analysis, was further utilized to assess and remedy all functional aspects of the RTA.

Critical analysis of participant narratives supported the identification, and development, of four themes with distinct central organizing concepts (Braun and Clarke 2013). The first three themes encapsulated the positive, or ideal, behavioral models countering the structural, clinical, and cultural deficit domains evidenced in the literature (e.g., Kcomt, 2019; Newman et al., 2021; Zwickl et al., 2019). The theme *structural competency* referred to the consciously affirming behaviors participant GPs enacted to mitigate people, process and institutional barriers to gender-affirming care. *Clinical adeptness* explored the nuanced approach affirming GPs used to apply their clinical expertise in the primary care encounter. Theme three *cultural companionship* considered the cultural aspects of the clinical encounter, where affirming GPs went beyond competency, to a position of companionship with the trans and gender diverse patient. The final theme developed from participant narratives was not evidenced in the literature review. Theme four *professional reward* explored the deep sense of professional fulfilment that gender-affirming primary care provided for the participant GPs, a marked contrast to the transactional and perhaps somewhat depleting nature of day-to-day general practice.

Results

Fully developed themes were analyzed and evidenced through narrative extracts from the respective participant to describe an exemplar of intersecting structural, clinical and cultural behaviors that might suggest positive change (Braun & Clarke, 2013). Identification of individual participant extracts was through a discrete *first-name* pseudonym as it better represented the informal, person-centered, approach and fluid power dynamics within the interview encounters (see Table 1).

[t]Table 1 near here[/t]

Structural Competency

This theme has as its central organizing concept how GPs negotiated, on behalf of trans and gender diverse patients, the structural impediments that are intrinsic to a cis-normative and cis-gendered medical infrastructure. Participants highlighted the need to continually mitigate and negotiate structural stigma with government institutions such as the federal Australian healthcare scheme, Medicare, and the associated Pharmaceutical Benefits Scheme (PBS). Sarah stated "we can't possibly have a different name on the file to the name that's in the Medicare box … institutions are … very hard work." Here Sarah expressed the essential, and largely unheralded, advocacy that affirming GPs performed to attain, and maintain systemic validation of their trans and gender diverse patients.

The informed consent model of care for trans and gender diverse patient hormone therapy was universally implemented by the participant GPs to support mitigation of structural stigma, with Claire asserting:

> I think it should be the only model to be honest. I mean it's pretty rare in my life as a gender-affirming doctor, in my career, I think it's been very rare that I've met someone who really needed to have extended psychiatric assessment before they started hormones. We need to give people that autonomy to be able to make those decisions, and I think informed consent is the ideal way to go through that process … when it comes to starting hormone therapy, I think that a GP is very perfectly placed to provide that care without any other medical person being involved in the assessment process.

However, some caution was voiced by Sarah that "probably it is a bit scary for inexperienced practitioners," but she clarified her comment by stating recent article publications in medical journals should serve to mitigate practitioner apprehension.

The conventional, and somewhat problematic, approach to initiate gender-affirming hormone therapy was described by Emma "The alternative model care is to require a person to see a psychologist, get a letter of confirmation … get them to see an endocrinologist." A process requiring multiple gatekeeping encounters, any of which may be non-affirming and stigmatizing. Participant utility of the informed consent model of care was pragmatically asserted by Thomas "I think it's a no brainer, why should it be any different than saying 'I want this skin cancer cut off', 'I want you to fix my broken ankle', 'I know the risks, I know the benefits, let's go.'"

Participant GPs successfully negotiated the challenges of appropriate, supportive, and timely referral pathways. An issue raised as a barrier to affirming care for trans and gender diverse patients by James:

> One of my biggest fears is saying "go see this person" even when it doesn't have to do with gender affirmation say … a trans person comes in with a broken arm, and they go to a physiotherapist who misgenders them and who doesn't know what that means, that's my worst nightmare.

A challenge compounded by both lack of experience in the field, and geographic distance from a metropolitan hub, Jenny with six months gender-affirming practice in a rural clinic expressed "a lack of feeling like I've got concrete avenues to give some people is really frustrating."

Until recently, two strategies were relied upon to ensure affirming referrals, the first being to maintain a personal list of trusted professionals, Emma for example had "a list of compassionate dermatologists, colorectal surgeons, so if I need to refer someone gender won't compromise the whole consultation." The second approach was to access

the established contacts of a gender-affirming mentor, with Henry declaring referral competency was initially premised upon "fortunately having a really good mentor … hadn't I had this mentoring I would have no knowledge of where to go, who to refer to." However, recent establishment of a gender-affirming professional network has added a third, and significantly beneficial referral source.

Sarah articulated how the GANQ professional network was already mitigating referral related obstacles "It's absolutely vital … we don't really know what kind of creature it's going to grow into because it's only just started … it provides networking, and that's the multidisciplinary thing that I was talking about that's so essential." Network participation was facilitating timely and appropriate referral pathways, with Thomas voicing "through the website you can post a question, and you get answers. This community of practitioners we have is extremely valuable, to not send someone to the wrong psychologist, to not send someone to the wrong endocrinologist, or surgeon."

Time pressure was not evident as an explicit barrier to gender-affirming healthcare in the literature. However, enacting person-centered care to diffuse obstacles of cis-normativity and minority stress takes time. Sarah posited the encounter is "much more holistic and time consuming to do well, that time needs to be valued." Several participants expressed challenges in providing sufficient time for their trans and gender diverse patients, for example James articulated:

> Time restrictions is one thing that I've found really difficult in terms of finding a great solution, I've found a lot of little solutions to make it manageable…in GP land where most consults are for fifteen minutes, none of my gender consults are for fifteen minutes, and I don't know how anyone can do that.

With no definitive resolution to time constraints, participants articulated how maintaining an effective process awareness, and setting clear patient expectations, were both essential to a supportive clinical encounter. Participant GPs exhibited an accessible

and nuanced knowledge of referral pathways and institutional processes that facilitated a focus on the person-centered needs of the patient without time consuming procedural distractions. An ability James described to his patients as "hoop-jumping is when I say hey we can totally do it, we just need to jump through these hoops, I didn't make up the hoops someone put them down there for us." To further mitigate consultation time pressure, James discussed his approach to expectation setting "I set really realistic expectations from the word go … and I found a way to explain that it's not gatekeeping, it's just making sure that one tablet doesn't make you explode." A more comprehensive, if aspirational, solution to the issue of time was posited by Henry "if I had a magic wand there'd be an item number looking after gender diverse individuals because of their complex needs." Public health insurance in Australia, Medicare, is supported through the Medical Benefits Schedule (MBS) providing rebates for specific healthcare services. Here Henry refers to a unique MBS provision code that would permit a longer consult for this patient cohort.

Clinical Adeptness

Accounts from trans and gender diverse patients generally describe a lack of cohort provider knowledge in the primary care encounter. However, the central organizing concept for this theme is not a lack of GP clinical knowledge per se, but rather a lack of adeptness in how to appropriately apply clinical knowledge in the trans and gender diverse consult. A pivotal adaption expressed by participant GPs being the ability to suppress six years of medical education in normal pathology, and embrace a construct of intentional physiological *derangement*, whilst adhering to the ethical premise of *do no harm*. Henry described his journey to gender-affirming practice awareness:

> It's obviously very apprehensive initially because coming from pure medicine, as in internal medicine … where my background was looking at physiology and our goal is

> not deranging physiology … the thought of changing someone's physiology with gender-affirming medical treatment was very a foreign concept to me.

The lead author asked Henry if this thinking ran counter to his medical training:

> Absolutely all of a sudden I am changing someone's physiology … and that was very anxiety provoking because I was thinking, am I going to cause this person harm by doing so … by changing their physiology and hence causing them harm in unintended means.

Henry was then asked how his perspective has evolved over six years of gender-affirming practice:

> It is pointless having the perfect physiology if you're so unhappy, and hence I've learnt through [Gender-affirming Mentor] … and all my colleagues in the gender-affirming field and becoming more comfortable with the fact that we can change physiology and not cause harm.

Henry's awareness journey was echoed by Emma, as she described comparing primary care interactions between cis-gendered, and trans and gender diverse patients:

> Same-same, absolutely the same it is no more complicated. They talk about the organ inventory, this person hasn't got a cervix I don't have to ask them about a pap smear, that this person hasn't got a prostate gland … it's a perceived complexity, that isn't really there.

The seven participant GPs graduated from Australian medical schools over a 36-year period, ranging from 1978 through to 2014. The almost complete absence of trans and gender diverse education in medical school syllabi was articulated by Claire "I think they talked about trans people in one lecture, on one day, in the entire six year course … what it did was cement this idea of an otherness of these people who are trans, and that there's something wrong with them." A sentiment echoed in more recent experience by James "in med school … we did not touch on any gender diversity … I did GP training from 2016 to 2018, and we didn't have any anything on gender diversity then." Once in

clinical practice participants voiced experiencing a lack of professional development pathways in gender diverse medicine, Emma asserted "I was a GP who wanted to see the system improve, I didn't know how to get the education to do it … I was looking through upcoming medical education, what can I do that's about gender-affirming? There wasn't anything."

Study participants were unequivocal in articulating how formal training in gender diverse medicine could benefit any GP in a trans and gender diverse encounter, an all-encompassing perspective voiced by James "because gender diverse people exist everywhere, I think it should be a part of everything … on a specific note for GPs I think as part of general practice training … part of the curriculum should be on … gender diversity and gender affirmation." Participants also consistently reference the intersection between clinical and cultural competencies in gender-affirming general practice, Henry articulated how that might appear in the medical curricula "it would be nice to have an LGBTIQ+ curriculum where we learn not just about gender, but also sexual diversity, and very importantly … the issues faced by members of the community, the discrimination that's the big one." Emma, reinforced the case for professional development, a need recognized whilst supporting her gender diverse child:

> I could see this big gap because going places with my son, I could see that the systems weren't great, things weren't set up for this … I really said to myself this could be better if there were doctors who were just more willing, and interested, and educated about all of this … that would be my suggestion, let's have some more visible professional development.

Participants were explicit in voicing that informal mentoring, and the few dedicated practitioners providing it, were vital to their achieving competency in gender-affirming practice. Thomas articulated his perspective on the importance of mentoring "I would say critical, I would say non-negotiable, I wouldn't ever recommend that anyone

commence on a journey of gender-affirming treatment without having at least a mentor and ideally a community of practitioners." A position echoed by Jenny a GP in rural practice, who expressed "it's been very much hit the ground running … but I've been very, very lucky with [Gender-affirming Mentor] he answers my phone calls … even if it's a Saturday morning and he's unpacking his shopping." Current mentoring is both informal and voluntary but has proved transformational in supporting interested practitioners' pathways to competence. Sarah, an active informal mentor, articulated how she approaches the role:

> At the moment I suggest to people that they make a parallel decision, so that they do that, but also maybe have a mentor … to give everybody a bit of support to go ahead, and then stop that second step later as they get more confidence, and I tell them about the literature that's already been published.

In response to lead author inquiry about the time required to achieve practitioner competency with mentoring support, Sarah answered "It depends a bit on caseload, but I think six to nine months … if you're seeing new patients, that would work because there's really not much else, it's not a specialty, there's no formal pathway." Informal, voluntary, and provided by a few recognized practitioners, mentoring was regarded by participants as an essential element to achieve gender-affirming practice competency for aspiring GPs.

Participants proposed that publishing of guidelines for gender-affirming clinical treatment might serve to mitigate knowledge deficits amongst practitioners. Claire argued that "we need to be able to direct doctors in this space to a set of guidelines that are endorsed, that are practical, and that tell them how to do it." Accessible, and endorsed hormone management guidelines for trans and gender diverse patients support the normalization of gender-affirming care as day-to-day clinical practice. Claire

explored this evolution in perspective, but cautioned there was still much work to be done:

> It's well covered in our education, we know those hormones, and we know how to prescribe them so we're well set up to be able to prescribe them for trans people, it's just that the doses are different … there's a lot of fear, and doctors fearful of doing something that's going to break a rule … we know that you can write prescriptions for all hormones and you can write any hormone on a private script that's fine … but there is a PBS indication for things like testosterone for trans men, and doctors don't seem to get it, they think they're going to break a rule if they do it … I think maybe now that guidelines are evolving that's less of a thing, but there's certainly still plenty of doctors out there who go "well I don't know how to do this, so I think it would be risky for me to do this."

Here Claire highlighted a specific barrier that confronts GPs when prescribing Testosterone for trans-masculine patients in Australia where a specialist second opinion is required to access subsidized medication under the PBS. However, by actively leveraging support from the few informal mentors, and utility of the recently published clinical guidelines, participant GPs compensated for their lack of formal training in gender-affirming medicine.

Cultural Companionship

Cultural competency is posited as an essential foundation to the provision of gender-affirming healthcare. Participant GPs, whilst explicitly acknowledging the need for cultural competency, voiced a more nuanced perspective with narratives describing a person-centered and longitudinal relationship with their patients, as succinctly put by James "if there's anything that I've learnt being on planet Earth this long, is that the best thing that you can give someone is validation." Reflecting on the participant narratives, the lead author reframed and extended the construct of cultural competency to a central

organizing concept of *cultural companionship*. A process initiated through participant agency for reflexive analysis of their own prejudices, Henry for example posited:

> As doctors we do our best, but we are still people, and we have our own ideas and biases. And we can't help it we're humans … but it's about parking that at the door and looking at it from the perspective of that patient, and going on that journey.

Having intentionally addressed their potential cis-normative biases, participant GPs set out to establish an environment conducive to patient comfort, safety, and positive regard, Claire articulated the approach:

> Connecting with patients, forming relationships with them. Your patients end up feeling comfortable and confident, and they can confide in you in a way that they might not be able to do with other doctors, and especially if you are able to be understanding of what they're going through, and make them feel comfortable in the consultation. I think it can be in some ways a safe haven, like a place to come to talk about things that you don't feel safe talking about elsewhere.

Vitally, participants articulated the need to listen and empathize with their trans and gender diverse patients. Sarah shared how her perspectives on gender identity were continually evolving in response to her patients:

> I've come to think in terms of I suppose, deep biology and deep neurology in terms of forming perception of gender, but very deep and very early and very real, and just as deep and early and real, even if it's not quite at one end or the other … I listen to what people tell me, and every time somebody tells me a personal story my model changes that much, and every hundred stories it's changed again.

With a beneficial therapeutic environment established, participants emphasized the longitudinal, and deeply engaging nature of the relationship with their trans and gender diverse patients, Henry elaborated:

> You have to take their journey, and I'm just here as a guy for want of a better word, or a friend, so that when they are in here they can use me as a sounding board, a friend,

> someone who understands them. To be able to guide them on the process, keep them safe. So that when they leave my room they leave with a sense of I'm being looked after, and I'm being listened to.

Participant GPs expressed that central to the premise of patients being listened to, was the considered and adaptive use of language. This included being open to accepting, and correcting, when missteps were invariably made, James disclosed "I had someone say that in the letter I wrote … I used a phrase that they found very dysphoria inducing … I was like oh no, I was also … how great that you can tell me that 'No James you can do better.'" The crucial nature of language in the gender-affirming encounter was further explored by Henry:

> Language is so important and it's sometimes quite difficult to know what language to use, so I'm always guided by my patients … and I have very interesting things like "my man wallet" … or "my women walnut" for prostate … and I've learnt over the years to use whatever language or terms that they wish to use.

The construct of cultural companionship in gender-affirming practice evidently shaped participant GPs clinical practice, and communication, in support of individual trans and gender diverse patient perspectives. The companionate, rather than transactional, nature of the relationship was further evidenced by participants going beyond the consulting room to advocate on behalf of their patients. Emma described advocating for an adolescent patient:

> I see a, under-eighteen, gender patient who's brought in by their mother, and the dad's not on board. I'm now more comfortable with saying, get him to come in and see me, or let's talk on the telephone, and trying to be an advocate for the child to the parent who is not really listening to what's going on.

Gender-affirming GPs, whilst attentive to the essential building blocks of cultural competency exhibited language and behaviors that transcended the transactional norms

of primary care, and situated the practitioner as both fellow traveler on, and advocate for, the trans and gender diverse patient's affirmation journey. Built upon a construct of cultural companionship, GP participants articulated a primary care relationship that had the potential to be rewarding for both patient, and practitioner.

Professional Reward

Burnout, or chronic emotional fatigue, is recognized as a significant issue amongst medical practitioners, James shared his perspective:

> It's really disheartening because I think it was really scary to feel so much burn out so early on in the career. I think I always had these magical ideas of what medicine would be like, what general practice would be like, and then you start to realize that it's a transaction.

A sense of professional dis-ease at, and lack of fulfilment from, general practice medicine as a career was articulated by Sarah:

> I did 12 months of locums, various general practices, most of which I hated … I just felt that if I sat in the suburbs and had a successful general practice for 40 years of the type that I'd seen, I would just think so what?

This theme, in contrast to the potential for practitioner burnout articulated in the narratives has a central organizing concept of professional fulfilment exemplified by a single term repeatedly and spontaneously voiced by participant GPs. That term *rewarding* was apparent to participants from the outset, Jenny after six months gender-affirming practice shared "It's definitely been a steep learning curve, but it has also been really rewarding, and I'm definitely glad I've started down this pathway." A perspective of professional and personal fulfilment was maintained as practitioners grew in experience, as Thomas with four years gender-affirming practice expressed "it's overwhelmingly satisfying … it's not super complex medicine, and it's very

professionally rewarding." However, the most emphatic articulation of the affirming nature of gender medicine for the practitioner was from James:

> I've found it's a type of medicine that holy moly it's just so rewarding, and I find in terms of the medicine, I feel it's one of the times where I get to truly be a facilitator … I think the beauty of these consults and these relationships is that I'm just the facilitator, I can help these people affirm something that is inside of them because I have skills, abilities, and a magic signature.

The potential for gender-affirming practice to buffer GPs against the risks of emotional stress and burnout requires research, but the possibility was explicitly articulated by Thomas "GPs are a caring bunch of people. We get very stressed and burnt out … if GPs knew that there was this area of medicine … that is really good, really satisfying, professionally rewarding, I think more people would come to the fold."

Discussion

The study set out to explore the *what*, *how,* and *why* of ideal primary care for trans and gender diverse Australians. The literature evidenced widespread deficiencies in care provision across multiple domains including, structural, clinical, and cultural capabilities (e.g., Kcomt, 2019; Newman et al., 2021; Zwickl et al., 2019). Despite moves to de-pathologize gender identity in DSM-V (APA, 2013) and ICD-11 (WHO, 2019), and progressive initiatives such as the informed consent model for hormone prescription (Cundill, 2020), trans and gender diverse patients continue to experience non-affirming primary care (Shepherd & Hanckel, 2021). Negative care encounters that serve to exacerbate minority stress, and adverse mental health outcomes for trans and gender diverse individuals (Zwickl et al., 2021). In contrast, trans and gender diverse population mental health and wellbeing has been shown to benefit significantly from

access to the gender-affirming and supportive primary care articulated by the participant GPs (Kattari et al., 2020; Swan et al., 2022).

Participant GPs described structural barriers premised upon cis-normative stigma including: non-inclusive forms, and cis-gendered pathology and other diagnostic procedures that were purposefully mitigated through an agile negotiation with healthcare institutions (Strauss, Winter, et al., 2020). An effortful process that Heng et al. (2019) suggest might be aided through leverage of endorsed guidelines (e.g. Cundill, 2020). A process both endorsed by the study participants and enhanced by the recent Australian Professional Association of Trans Health publication of *Australian Informed Consent Standards of Care for Gender-Affirming Hormone Therapy* (AusPATH, 2022). A comprehensive guide for GPs that seeks to "help reduce barriers and improve health outcomes for trans people of all genders" (AusPATH, 2022). Lack of appropriate, supportive and timely referral pathways has been reported as a significant barrier to effective gender-affirming care provision (Heng et al., 2019; Snelgrove et al., 2012). Until recently a challenge mitigated by gender-affirming GPs through maintenance of personal networks, or seeking mentor support. Snelgrove et al. (2012) hypothesized that a "physician support network" (p. 10), could serve to mitigate referral related obstacles for GPs. In Queensland establishment of GANQ, whilst still an informal organisation, has transformed the ability for practitioners to effectively access affirming referral pathways across disparate healthcare disciplines.

In studies almost half of Australian trans and gender diverse adults have reported a lack of cohort specific healthcare knowledge in their medical encounters (Newman et al., 2021; Zwickl et al., 2019). However, participant GPs voiced a perspective that it was adept holistic application of normative clinical knowledge, rather than some cohort specific medical proficiency, that facilitated their gender-affirming

care. Participant narratives described a journey to gender-affirming competency reliant upon an exposure to holistic practice through the enduring support of informal mentors. A considerable body of literature puts the case for trans and gender diverse training and professional development (e.g., Grant et al., 2020; Mullens et al., 2017; Newman et al., 2021; Strauss, Winter, et al., 2020). However, this study highlighted the need for curricula emphasis to be on facilitating cultural companionship, and the appropriate application of standard clinical capabilities, rather than trans and gender diverse specific clinical knowledge.

The authors were struck by the expression of "unconditional positive regard and acceptance" (Corey, 2016, p. 175), directed toward their trans and gender diverse patients by participant GPs. Defined by humanist psychologist Carl Rogers as a therapeutic core condition in the provision of person-centered care and perhaps epitomized by an approach without unnecessary evaluation or judgement (Corey, 2016). An expression of validity modelled by participant GPs that sought to foster an environment conducive to diffusion of patient minority stress (Hendricks & Testa, 2012). A second of Rogers' core conditions also evident in the narratives was that of "accurate empathetic understanding" (Corey, 2016, p. 175). A capacity for participant GPs, time constraints notwithstanding, to attain a deep understanding of the patient, with the patient (Corey, 2016). A person-centered perspective that Heng et al. (2019) reported as a pivotal influence on trans and gender diverse patient healthcare experience. Participant GPs consistently modelled behaviors that embraced both professional cultural competency, and Rogers's core conditions for therapeutic benefit, a capacity reframed in this study as one of cultural companionship.

A novel, albeit important aspect of gender-affirming practice not observed in the literature, but unanimously voiced by the participant GPs, was that of professional

fulfilment. The extent of both professional and personal reward participants gained through gender-affirming practice was not anticipated. GPs, particularly earlier in their professional careers, are reported to encounter a considerable degree of emotional stress and burnout (e.g., Kumar, 2016; Willcock et al., 2004). However, multiple participants articulated how the rewarding nature of gender-affirming practice buffered them against the somewhat depleting stressors of day-to-day transactional primary care.

Conclusions

For GPs, an almost complete absence of trans and gender diverse education throughout six years of medical training and a paucity of professional development thereafter requires redress. The dedicated, but small, cohort of experienced gender-affirming practitioners is unable to meet an unrelenting increase in demand as the visible trans and gender diverse population continues to grow and seek out primary care support. It should be incumbent upon university schools of medicine to develop and incorporate holistic, informed consent, and standards of care focused courses premised upon the practice of cultural companionship established in this research. Professional colleges and public-health institutions should in turn leverage medical school courseware to provision the necessary professional development of practitioners in the field. Competency in gender-affirming practice could also be considered within the context of GP social and emotional wellbeing. Further research is required to understand and quantify the potential buffering effect offered by gender-affirming practice from the emotional stress and burnout experienced by GPs.

Participant GPs and the literature consistently identify the provision of timely, appropriate and supportive referral pathways as a barrier to gender-affirming care. Participant narratives described how both mentoring and the recently established peer support network were essential in their capacity to provide effective referrals. Avenues

should be explored by relevant professional bodies and public institutions into ways of formalizing, funding, and expanding these roles and networks in support of growing trans and gender diverse care needs.

The relationships between trans and gender diverse patient wellbeing and time constraints within the primary care encounter requires further study. Participant GPs, whilst declaring clinical normalcy in the gender-affirming encounter, stated the need to establish a person-centered and empathetic consulting space. Diffusing minority stress and promoting an environment conducive to a beneficial therapeutic relationship takes time. Further research could explore the relationship between consult duration and patient wellbeing, to quantify the potential benefit of a longer trans and gender diverse clinical consult, perhaps through a specific Medicare provider code.

This study was in part limited through intent, with a singular aim to describe an ideal model of gender-affirming care in Australian general practice, explored in contrast to less affirming behaviors evidenced in the literature. Recognized gender-affirming GPs are a small, and passionate cohort. Whilst their experience and dedication to gender-affirming practice facilitated the collection of a rich dataset, their very homogeneity may limit the range and diversity of practice narratives expressed. Only one participant practiced in a rural setting, limiting the scope of non-metropolitan perspectives in the findings. The lead author was contextually situated as both a trans woman, and partial insider researcher, a position that supported a considerable degree of disclosure amongst participants. However, the risk of inherent bias from both lived experience, and enmeshed status should be acknowledged, and may have limited critical reflexivity.

This research has offered a contemporary construct of what gender-affirming primary care can look like within the Australian GP setting. A construct delivered

through effortful mitigation of structural barriers, and a person-centered, empathetic, and culturally companionate enabling of trans and gender diverse patient care. Professionally rewarding work that may buffer the GP against the ever-present risk of professional burnout. As such, this paper contributes rich and novel knowledge that may provide the foundation for necessary beneficial change across the broader Australian primary care community.

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Table 1.

Participant Information

Pseudonym	Practice Focus	Practice Location	Gender-affirming Experience
Claire	LGBTIQ+	City	20 years
Emma	LGBTIQ+/Family	City	3 years
Henry	LGBTIQ+	City	6 years
James	Family	City	2 Years
Jenny	Family/Indigenous	Rural	6 Months
Sarah	LGBTIQ+	City	30 Years
Thomas	Family	Regional Urban	4 Years