How can the process of professional identity formation of a gender-affirming practitioner inform medical curriculum change?

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ABSTRACT

Background

Transgender and gender diverse people experience significant health disparities. Health professionals are generally not adequately prepared by current curricula to provide gender-affirming, holistic care that is respectful of patients' gender identity. Therefore, this study asks the question: How can the professional identity formation of a gender-affirming practitioner inform medical curriculum change?

Methodology

The objectives of the study were to:

a. Analyse the process of professional identity formation of gender-affirming health care practitioners and students, using narrative interviews.

b. Illuminate how medical curriculum change can enable gender-affirming professional identity formation.

A critical research paradigm using the conceptual lens of professional identity formation was adopted. Case study design and narrative inquiry were the complementary methodological frameworks used. The study was conducted in two phases. In Phase One, six health care practitioners and nine medical students described their shared their experiences of becoming gender-affirming practitioners through narrative interviews. A narrative analysis was conducted and represented as stories. In phase two these stories were shared with medical educators in a group engagement to facilitate their reflections on gender-affirming curriculum change. Reflexive thematic analysis was used to analyse this discussion. Regulatory policy and university curriculum documents were analysed. Other data sources were participant reflective journals from phase one and the researcher's reflective journal. Findings from each phase were combined for the case study analysis using a critical lens.

Findings

The process of professional identity formation is described as a journey of becoming over time rather than a destination. Being gender-affirming entails providing holistic

care, confronting pathologising perspectives, seeing the human first, and shifting power to enable patient participation.

The present learning environment at medical schools is not conducive to the development of a gender-affirming practitioner, given the gap between the intended and experienced curriculum.

Conclusion

A gender-affirming approach offers a new perspective of how power dynamics may shift to create a more enabling environment for the development of a gender-affirming professional identity. Curriculum change can facilitate this approach by integrating gender-affirming healthcare into the medical curriculum with a focus on attitudes, cultural humility and incorporating the voices of transgender and gender diverse people.

DECLARATION

I, Elsje Maria de Vries, hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.
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De Vries, E., Kathard, H., & Müller, A. (2020). Debate: Why should gender-affirming health care be included in health science curricula? *BMC Medical Education*, *20*(1), 51. https://doi.org/10.1186/s12909-020-1963-6

Signature: Signed by candidate **Date:** 7 February 2024

Student Name: EM de Vries **Student Number:** DVRELS001

DEDICATION

I would like to dedicate this thesis to Randi, a transgender woman from a small town in the Northern Cape, from whom I learnt so much about the meaning of being affirmed, and to the transgender and gender diverse people on this crazy, cruel, beautiful continent of Africa, who yearn for the healthcare they need to live as their authentic selves.

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Dr Nadia Hartman for skilful editing.

Suki Lock of Jagged Daisy (www.jaggeddaisy.co.za) for the graphic design.

“Hope is a natural, possible, and necessary impetus in the context of our unfinishedness. Hope is an indispensable seasoning in our human, historical experience.”

(Freire, 1998, p. 69)

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List of Abbreviations/Acronyms

AFAB – Assigned female at birth
AMAB – Assigned male at birth
AMEE – An International Association for Health Professions Education
APA – American Psychiatric Association
ASD – Autism spectrum disorder
BOD – Burden of disease
CBME – Competency Based Medical Education
DSM – Diagnostic and Statistical Manual of Mental Disorders
DSD – Differences in sex development
GA – Gender-affirming
GAC – Gender-affirming care
GAHC – Gender-affirming healthcare
GBV – Gender-based violence
GNC – Gender non-conforming
GP – General practitioner
HC – Hidden Curriculum
HIV – Human Immunodeficiency Virus
HPE – Health Professions Education
HPCSA – Health Professions Council of South Africa
HSRC – Human Sciences Research Council
ICD – International Classification Of Disease
LGB – Lesbian, Gay, and Bisexual
LGBT – Lesbian, Gay, Bisexual and Transgender
LGBTI – Lesbian, Gay, Bisexual, Transgender and Intersex
LGBTIQA+ – Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual and others
PATHSA – Professional Association for Transgender Health South Africa
PIF – Professional Identity Formation
PsySSA – Psychological Society of South Africa
RToP – Ring Theory of Personhood
SA – South Africa
SAAHE – South African Association of Health Educationalists

SDOH or SDH – Social determinants of health

SDG – Sustainable Development Goals

SoC-8 – Standards of Care 8

SOGI – Sexual Orientation and Gender Identity

STI – Sexually transmitted infection

TB – Tuberculosis

TGD – Transgender and gender diverse

TL – Transformative Learning

UCSF – University of California San Francisco

UCT – University of Cape Town

UN – United Nations

US – Stellenbosch University

USA – United States of America

WHO – World Health Organization

WMA – World Medical Association

WPATH – World Professional Association for Transgender Health

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PROLOGUE

Marginalised people have been my interest from a young age. As a child I became aware of apartheid, class differences, prejudice, and homophobia.

I grew up as a white girl in South Africa. My father was a reverend in the Nederduitse Gereformeerde Sendingkerk (Dutch Reformed Mission Church), the branch of the Dutch Reformed Church founded for so-called ‘coloured’ members. I met people such as Reverend Alan Boesak (a well-known religious leader and political figure) and learnt to respect all people as “God’s children”, regardless of their background or skin colour, as a result of my parents’ role-modelling.

Class and race differences were very stark, as most of my father’s congregants were farm workers, and the children in the school I attended were all white and mostly the children of farmer owners or farm managers.

I became a medical doctor and spent years working at a rural hospital before moving back to Cape Town. The rural experience exposed me to vast inequalities and strengthened my resolve to work towards improving access to healthcare.

In Cape Town I joined a faith community that was radically inclusive. It was in this group that I experienced first-hand, the transition of a close friend, from the moment of realisation that she was transgender, to accessing hormones and eventually surgery. This led to many questions: Was I prepared to help someone transition? More so, was the medical world, to which I belonged, ready to help transgender patients who needed gender-affirming health care? As medical educators, how do we prepare our students to become affirming care givers?

Chapter 1 Introduction

This chapter will start with the background and purpose of the study, followed by a discussion of my positionality as researcher. This will be followed by a brief introduction to the study design and theoretical framework and conclude with a brief outline of the chapters in the thesis.

1.1 Background and rationale for the study

The 2030 agenda for sustainable development adopted by the United Nations in 2015, works towards a world that reflects equity and universal respect for human dignity, with the aim of leaving no one behind (UN, 2015). However, transgender and gender diverse (TGD) people experience significant health disparities, "including negative health outcomes and multiple barriers to accessing care" (Hana et al., 2021, p. 296). "Transgender and gender diverse" is a broad umbrella term that refers to individuals with "gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth" (Coleman et al., 2022, p. S11) and the term "cisgender" is used for individuals "whose gender identity is the same as that normatively expected on the basis of their assigned sex" (De Vries et al., 2020, p. 2). The barriers to accessing care include significant marginalization and discrimination in health care settings (Reisner et al., 2016).

In health-care systems globally, there are gaps both in addressing the specific health needs of TGD people as well as in providing general health care to this group with acceptable sensitivity, dignity, and respect (Hana et al., 2021). Health professionals are generally not adequately prepared by current curricula to provide either aspect of this care (E. De Vries et al., 2020; Dubin et al., 2018).

There are strong voices calling for the redesign of health professional education, both internationally (Frenk et al., 2010; Kruk et al., 2018) and in South Africa (Academy of Science of South Africa, 2018; Jacobs et al., 2020). There is a move in medical education away from an exclusive focus on "doing the work of a physician" toward a broader focus that includes "being a physician" (Jarvis-Selinger et al., 2012, p. 1185). Professional identity formation (PIF) is recognised as an important aspect

of medical education and includes the development of professional values and moral principles, with ongoing self-reflection (Wilson et al., 2013). Although the ideal is to graduate health professionals with a professional identity that will be respectful of diversity (Health Professions Council of South Africa, 2011), how patients from marginalised groups such as TGD people experience health professionals is often far from this ideal (Luvuno et al., 2019).

There is an imperative to decolonize health professions curricula in South Africa (Pentecost et al., 2018). Decoloniality is defined by South African author Thirusha Naidu as “delinking from the overall structure of knowledge to reconstitute ways of thinking, languages, ways of life, and being in the world. Decoloniality foregrounds reclaiming, reframing, and recentering of Indigenous knowledge systems, methods, and languages and correcting deficits created by colonialism and maintained by coloniality” (Naidu, 2021a, p. S9). Behari-Leak & Mokou (2019) wrote that decolonisation and de-coloniality refer to the gesture of delinking from coloniality, to allow the colonised to un-learn certain orientations, values, and actions instilled by the colonial regime (Behari-Leak & Mokou, 2019). This can allow previously silenced voices and the perspectives of those who are marginalised to be heard (Behari-Leak & Mokou, 2019). In a South African context this means not simply accepting how curricula have been shaped by Global North knowledges, but to critically consider what is relevant in our context (Naidu, 2021b).

Gender-affirming health care (GAHC) is “health care that holistically attends to transgender people’s physical, mental, and social health needs and well-being while respectfully affirming their gender identity” (Reisner, Radix, & Deutsch, 2016). The gender-affirmative model has been described by Hidalgo et al. (2013) in the context of services for gender-nonconforming children in the USA, as facilitating the expression of gender with freedom from restriction, criticism, or ostracism (Hidalgo et al., 2013). Rider et al. (2019) describe a trans-affirmative approach as one “that centers transgender voices and experiences, and asserts that being transgender is an identity, not a disorder” (Rider et al., 2019; p. 279). To view being transgender as a disorder is pathologising, and a strong argument has been made for depathologisation (Castro-Peraza et al., 2019).This will be discussed in more detail in the literature review (Chapter 2). From a family therapy perspective, McGeorge et

al. (2021) define affirmative therapy for TGD people as “an approach to therapy that both embraces a positive, celebratory view of diverse transgender and non-binary identities and relationships” (McGeorge et al., 2021, p. 785). The South African Gender-affirming Guideline outlines the different components of GAHC as including primary and preventative care (general healthcare), psychosocial care, as well as transition specific care such as medical therapy, surgery and voice and communication therapy (Tomson et al., 2021).

A focus on the health needs of sexual and gender minority groups is not uncontested terrain. Although sexual and gender minorities are different concepts, that will be explored in more detail in the Literature review in Chapter 2, these groups often have shared experiences of social exclusion, stigma, discrimination, violence, as well as ignorance from health professionals (Ard & Makadon, 2012). Around one third of United Nations member states still criminalise consensual same-sex sexual acts between adults (International Lesbian Gay Bisexual Trans and Intersex Association, 2020). A report titled “Our identities under arrest” found that TGD people are often targeted under these laws, with arrests of people with non-conforming and diverse gender expressions, even when legislation does not target them explicitly (International Lesbian Gay Bisexual Trans and Intersex Association, 2021). On the African continent, there has been an outcry about the recent Anti-homosexuality Act in Uganda (Machingura & Shahmanesh, 2023), with professional organisations such as the Professional Association for Transgender Health South Africa (PATHSA) expressing concern that it would drive communities away from life-saving health services (Professional Association for Transgender Health South Africa, 2023). In the United States of America (USA), legislation recently introduced in several states to ban access to GAHC for TGD children and adolescents younger than 18 years, has been condemned by the World Professional Association for Transgender Health (WPATH) as lacking scientific grounding (World Professional Association for Transgender Health, 2023).

TGD people internationally experience significant health disparities and an increased burden of disease as compared to cisgender people (Noonan et al., 2018). This will be discussed in more detail in the literature review. Many of these disparities originate from discrimination and systemic biases that decrease access to care and

from inadequate knowledge amongst health professionals, that contributes to unmet medical needs (Donald et al., 2017). TGD people in South Africa often have negative experiences of accessing health care (Luvuno et al., 2019; Müller, 2017). Müller et al (2019) reported that 39% of South African TGD study respondents said that they had been denied access to healthcare because of their gender identity (Müller et al., 2019). A recent South African key population report indicated that 49% of trans respondents said that the reason for not accessing healthcare at all is unfriendly services (Treatment Action Campaign et al., 2023).

In South Africa, in both the private and public sector, access to GAHC remains severely limited and unequal (Spencer et al., 2017). In terms of curriculum, there is a huge gap in teaching about GAHC (Luvuno et al., 2017; Müller, 2013). A study of health professions education in South Africa and Malawi found that the formal inclusion of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) health topics in nursing and medical education is minimal (Müller et al., 2017). At the time that I started with this PhD in 2018, there were no official guidelines for GAHC in South Africa. The Southern African HIV Clinicians Society Gender-affirming Healthcare Guideline for South Africa was published in October 2021 (Tomson et al., 2021). In 2019 gender-affirming hormones were approved by the South African National Essential Medicine List Committee (NEMLC) for tertiary level of care (Department: Health Republic of South Africa, 2019). While this is a recognition of GAHC as essential care, classification at tertiary level of care still results in limited access for many TGD people in South Africa. The 2021 guideline makes a strong argument for GAHC to be available at primary care as part of a comprehensive package of care (Tomson et al., 2021).

In order to reduce health disparities of TGD persons, education of health professionals is critical. But how does it happen that someone becomes a gender-affirming practitioner? It will be helpful to explore this, before suggesting how to include GAHC into a medical curriculum. There is the danger otherwise, to add:

> quick-fix courses like gender-studies modules to a curriculum or call in random experts to do presentations on LGBTI issues. Because this kind of curriculum intervention does not involve restructuring the philosophical underpinnings of the

> curriculum, the canon therefore remains intact. Issues of equity and social justice are also not effectively addressed in this way (Reddy, 2018, p.165).

Reviews have been published of the evidence for educational interventions to increase medical student knowledge and confidence in caring for TGD patients (Desrosiers et al., 2016; Dubin et al., 2018; Nolan et al., 2020; Sekoni et al., 2017). Overall, the authors reported that while all studied interventions seemed to improve participant knowledge, confidence or attitudes in post-intervention testing, the one-time nature of interventions and the absence of long-term follow-up data were limitations (Dubin et al., 2018; Nolan et al., 2020). Longitudinal curriculum interventions that are combined with interventions to shift the culture of medical education is recommended (Hana et al., 2021).

A focus on social justice in medical education has been highlighted by medical educators as important, in order to reduce health disparities (Association of American Medical Colleges, 2014; DasGupta et al., 2006). This is considered part of a process of decolonising health science curricula (Pentecost et al., 2018). Understanding the process of how a medical student can become a gender-affirming practitioner, using the lens of professional identity formation, could provide valuable insights to inform medical curriculum change.

1.2 Phenomenon and critical questions

The phenomenon that will be explored in this study is the professional identity formation of a gender-affirming medical practitioner to inform a relevant medical curriculum.

The critical questions are:

- What is the process of professional identity formation of a gender-affirming health care practitioner?
- How can curriculum change enable the professional identity formation of a gender-affirming practitioner?

1.3 Aims & Objectives

The aim of this research was to explore how medical curriculum change could enable the professional identity formation of a gender-affirming practitioner.

Objectives

a. To analyse the process of professional identity formation of gender-affirming health care practitioners and students using narrative interviews.
b. To illuminate how medical curriculum change could enable gender-affirming professional identity formation.

1.4 Brief remarks about terminology

Terminology in the field of gender-affirming healthcare (GAHC) is evolving (Tomson, 2018) with some terms used in older publications no longer recommended (Bouman et al., 2017). The newly published WPATH Standards of Care 8 (SoC-8) state that "differences and debates over appropriate terms and specific terminologies are common, and no single term can be used without controversy" (Coleman et al., 2022, p. S11). This controversy is about different views of the exact meaning of specific terms as the terminology is evolving. Vincent (2018) cautions that because there is an entwined relationship between language use and transgender history, researchers need to pay careful attention to shifts in meaning over time (Vincent, 2018). For this thesis I will use the term transgender and gender diverse (TGD) as recommended by WPATH SoC-8, though in the article we published in 2020 that is included in the Literature review chapter, the term trans and gender diverse (TGD) was used. I also had the dilemma whether to use 'client' or 'patient'. I recognise that being TGD is not a pathology, and people who access GAHC may not think of themselves as 'patients' as they do not have an illness. For this reason, the South African GAHC Guideline used the term 'client' (Tomson et al., 2021). If I look at the Medical Education literature though, 'patient' is mostly used, and this is the term I will use in this thesis.

1.5 Narrative beginnings – my own positionality and how this shifted during the PhD journey.

I started telling my story in the prologue.

1.5.1 Activist community

I have been part of an activist community in transgender health over several years. When I started the PhD in 2018, I was a board member of the NPO Gender DynamiX (2016-2019). Since then, we have established the Professional Association for Transgender Health South Africa (PATHSA) of which I am the board secretary. PATHSA was formally established as a voluntary association on 6 October 2020. I wrote in my reflective journal:

> The process was wonderful, with different people contributing to the final constitution. We tried to get trans professionals on board, and in the end more than half of both the founding members and board are TGD. The discussions were so rich, focusing on the power dynamic in the consultation and how we want to change it. This has the potential to change medical practice. It is wonderful to be part of a group of people who share similar ideas. And those ideas are so closely linked to this PhD work.

After attending the World Professional Association for Transgender Health (WPATH) symposium in November 2020, I wrote:

> Wonderful to be with people interested in improving trans health, from 35 countries! It feels like a good tribe to belong to. And I am affirmed, received positive feedback after my presentation and the panel discussion. I feel confident in contributing, I can speak the language, express humility about not speaking on behalf of black South Africans, bring ideas about how we do things here.

In these international conversations, that are often dominated by voices from the global north, it is important to point out global south perspectives, but at the same time being very aware of my privilege as a white educated person, that cannot speak on behalf of black South Africans.

I am related to my research participants through friendships, being fellow activists for GAHC and as someone who identifies as non-binary. This awareness of my own

gender identity grew over time during the time of this research. When I was asked to join the board of Gender DynamiX in 2016, I had to answer the question: are you cisgender? I knew that I was not, and at that time identified as gender nonconforming. That is now considered an old / outdated word by some people, especially some gender activists. It is mentioned in the Chapter on terminology in Soc-8 that the authors decided to avoid gender nonconforming as a term (Coleman et al., 2022). I still quite like it as it describes who I am, I do not like to conform! I wrote in my reflective journal in 2021: “I do not really like labels and would just want to be me, but in the trans political space it does matter how one identifies”. Terminology in this field is fluid and evolving. After a lot of reflection in 2021, I decided to use the term non-binary to refer to my gender identity, as it is an umbrella term that includes gender nonconforming. In certain activist spaces as well as when training on GAHC, it is useful for me to be able to express how I identify.

I wanted to do this research because there is a need, because I wanted to make a small contribution. I frequently hear stories of TGD persons having negative experiences with health workers, and how doctors are ignorant about GAHC. I really wish that every doctor would understand and have the knowledge and skills to treat a TGD person competently.

My research was located in a vacuum, with no official guidelines for GAHC in South Africa at the time that I started with the PhD in 2018. I was part of a team of authors who developed the first national guideline for GAHC in South Africa, that was published in October 2021. I wrote in my reflective journal:

> The guidelines took a lot of dedicated time; it was critical to put in the effort to have a good product for the launch on 20 October 2021. It was good learning for me, I have read so much about the whole GAHC field, from chest-feeding to pregnancy in trans men to surgery, a deep dive into informed consent and the tensions there, the legal aspects with interaction with the legal team. And in the bigger picture of my PhD, this is the content part of what we want students to know the basics of. The way the guidelines were written and the journey as a team, with a strong emphasis on autonomy and depathologisation, while being careful to have a rigorous process, was a good learning experience for me. It is a delicate balance, and remains a tension in the wider trans world, where some activists are fundamentalist in their approach,

> wanting everyone to just access treatment quickly if they say they are trans, regarding a proper assessment process as ‘gatekeeping’.

While the guidelines provided a thorough theoretical basis of what a gender-affirming practitioner needed to know, the question remained how to facilitate the process of becoming gender affirming, which is the focus of this study.

I am one of the authors for the Primary Care chapter of the new WPATH SoC-8. It was a powerful learning experience to be part of an international group writing these guidelines and gave me more exposure to the latest thinking in the field of GAHC. It was finally published in September 2022. The tension between an “assessment” and facilitating access to care was very much part of the process of developing these guidelines. I brought the perspective of the global south as one of a small group of authors who were not from the global north, that emphasised the role of primary care as we do not have the same level of access to specialists as in the global north.

Emic and etic are terms from anthropology, with etic an outsider perspective and emic an insider perspective (Beals et al., 2020). These are not in simple opposition, and it is described by Beals et al. (2020) as researchers occupying the margin between multiple worlds and perspectives, with emic and etic research lenses complementing each other (Beals et al., 2020). In terms of GAHC, I bring aspects of both perspectives – an insider in terms of being part of the group of TGD people, an outsider in terms of not having a need to access GAHC for myself. Some activists only regard binary trans people as insiders and judge non-binary people as not trans enough. I have experienced this as a contested space. Being a doctor gives me an insider perspective in the world of medicine, but I am sometimes regarded as an outsider by conservative colleagues because of being outspoken about GAHC.

1.5.2 Positionality with student participants

In May 2021, I reflected on my positionality with the students that I interviewed. There was a potential power differential, with me being a lecturer at the medical school. As I was involved with 6th year teaching, I did not have any teaching contact with the students prior to the interviews, as they were either in more junior years, or at another institution. My sense is that they perceived me as an ally – most of them

identity as ‘queer’ or part of the LGBTIQ+ spectrum. I got the impression that they felt they could speak freely. I received wonderful comments from students about the research:

> I think this kind of research is important, umm, particularly in transforming the way that gender-affirming care is thought of … (B, cisgender student);
>
> I’m really inspired by the work that you are doing and I’m excited to see where it goes (TB, cisgender student);
>
> I am very interested to see the outcome of your research. And maybe it could be presented to the universities, at least in South Africa, to have them put a little bit of colour into their curriculums, like a nice little rainbow flag somewhere, you know (CM, cisgender student).

1.5.3 Professional identity

My professional identity is that of a family physician. Up to February 2022, this included clinical, management and teaching roles. I see myself as a clinical educator, and my long-term career plan was to be in medical education. From March 2022 I am in a teaching and management role as the MBChB programme coordinator as Nelson Mandela University. This provides a space for me to reflect on the PIF of our medical students, and to contribute to shaping it.

1.5.4 Paradoxes

In discussions with my supervisors, a tension became apparent, that I want to improve healthcare (which could be seen as quite positivist) but it happens in the discipline that marginalises and pathologises trans identities (critical perspective). There is a depathologisation movement. I had to ask whether I am coming from a pathologising angle, from my biomedical background that wants to “fix things”? The debate about depathologisation of trans persons has many different perspectives, which is discussed in detail in the literature review (Chapter 2). My perspective is that in our current health system context it is necessary to have a diagnosis to access care, but that does not mean we have to regard gender diversity as an illness. It is The ICD-11 process has been very helpful in this regard and will be discussed in detail in Chapter 2.

There has been a subtle shift in how I think about ‘patients’. Although in Family Medicine I have been trained in person-centred care (Mash, 2016), in practice I still saw a lot of ‘othering’ (Johnson et al., 2004). Having friends who are TGD has helped me to see the human journey as people ‘transition’ to affirm their gender identity. Through my work with the NPO Gender DynamiX I have met different TGD people, and some do not actually like the term ‘transition’, for example a trans woman said, “I have always been a woman, so I am not ‘transitioning’ from male to female”.

In my reflective journal:

> It is a paradox, trying to understand what it means to be gender affirming, as a medical professional, when the fundamental of what it might mean to be gender-affirming is to reject medical definitions and ideas about what is the norm. The paradox sits in a much wider framing of contesting pathologisation, contesting colonial ways of knowing.

In a conversation about self-reflexivity, I was asked, what has medicine done to you, how has it distorted your thinking? It was difficult to try to answer this question. In my reflective journal, I wrote:

> If I reflect on it, in the trans world there is a complete rethink about pathologising certain identities. I was trained to think like a doctor, look for what is wrong (pathology) and try to cure it. Trained in the context of a power hierarchy between the doctor who ‘knows what is good for the patient’, and the patient. To some extent my postgraduate training in Family Medicine has challenged my undergraduate training already, with the concept of the consultation as a meeting between experts, and the patient an expert on their own experience. To think about a gender-affirming approach where one is respectful of whatever the patient brings, is a step further.

1.5.5 Health Professions Education

I have come to understand a bit more about the discourses in health professions education through involvement at South African Association of Health Educationalists (SAAHE) conferences, attending an International Association for Health Professions Education (AMEE) conference and reading in the field, and I am fascinated with how things are changing. It feels to me that the awareness of

pedagogy / how we teach is quite recent in medical schools in South Africa. Rather than it just being an apprenticeship model, there is reflection on what we teach, how we teach, what outcomes we want to achieve. After attending the AMEE conference in 2020, I wrote in my journal: “It is inspiring to be part of a health professions education community that all have in common that they want to do things better.”

I realised that for the PhD I must wear a researcher hat and focus on the educational aspect more than the clinical aspect. The danger as a clinician is to want to do it superficially and get to the product (for example, an online course), but as a researcher I need to go deep into the theory to have something that will be worthwhile to influence curriculum later. It has been a journey for me, coming from a positivist medical background, to learn the discourse of education and the humanities and adopt a critical pedagogy perspective.

I have been a medical educator since 2001 and lived through the tumultuous period of the “Fees must fall” student protests in South Africa in 2015 and 2016 (Booysen, 2016). Students led a country-wide protest movement, fighting for free higher education and the decolonising of university curricula and institutional cultures (Tsampiras & Müller, 2018). This movement challenged universities to respond to critical issues raised by students and to reconsider what we teach and how we teach (UCT Curriculum Change Working Group, 2018). It has definitely influenced my thinking, as will become more evident in Chapter 6, when I discuss student critique of the curriculum.

I wrote in my reflective journal in May 2021:

> This is actually such a messy field I am involved in – not a neatly delineated field. I read about trans health very broadly, for the guideline development. And I read about medical education broadly and specifically about professional identity formation.

This speaks to the interdisciplinary nature of this study.

In Oct 2022, I reflected in my journal:

> I dance in this in between space, where it is about medical education (the professional identity formation and curriculum stuff), and it is about being gender-

affirming, keeping up with the international thinking in trans health, and active in national processes to improve access to GAHC. What a privilege to do this dance!

1.5.6 Positionality influence on the research process

I must be upfront about the fact that I am not objective. As someone who is part of the TGD community, I feel very passionate about the need to improve GAHC through education. This certainly influenced how I did the analysis and meaning making. I know the practitioner participants as fellow activists and could interpret their narratives in a bigger context. They trusted me and were able to share their stories openly, in a way that might not have been possible with a researcher who is a cisnormative and heterosexual doctor. My positionality as a medical practitioner and medical educator had an influence as well, as discussed above.

1.6 Introduction to Study Design

This qualitative study used case study design together with narrative enquiry as complementary methodological frameworks.

The case for this study is the process of PIF of a gender-affirming practitioner in a South African context. The case is bounded in terms of participants, location, process to be explored and timeframe, described in detail in the Methodology chapter. The study context is South African Healthcare in 2019-2020.

The study was conducted in two phases. In the first phase six health care practitioners as well as nine medical students were purposively sampled for individual interviews and a narrative analysis was conducted. In phase two the narrative analysis, represented as stories, was presented to a purposive sample of medical educators to explore ways of developing a gender-affirming curriculum; their discussion was analysed using reflexive thematic analysis. Regulatory policy and university curriculum documents were analysed as part of phase two. Other data sources were participant reflective journals from phase one and the researcher's reflective journal. Findings from the different data sources were combined for the case study analysis. Level one analysis is the narrative analysis, generating the

stories; level two analysis is the reflexive thematic analysis and level three analysis the thesis building, consolidating the case.

1.7 Introduction to Conceptual Framework

The conceptual lens of professional identity formation (PIF) was used to explore this topic. PIF is "the transformative journey through which the knowledge, skills, values, and behaviours of a competent, humanistic physician is integrated with one's own unique identity and core values" (Holden et al, 2015, p. 762). PIF has been described as a series of processes with overlapping domains of professionalism, psychosocial identity development and formation (Holden et al., 2012). The description by Cruess et al. (2015) of the multiple factors that influence the shaping of a doctor's professional identity, was useful in analysing the data. This will be discussed in detail in Chapter 3.

1.8 Organisation of the thesis

The remaining chapters in the thesis have been arranged as follows:

Chapter 2 Literature review: includes a published article, titled "Debate: Why should gender-affirming health care be included in health science curricula?", that gives a rationale for this study, based on a literature review. The history of pathologisation of TGD identities, gender-related health disparities experienced by TGD people, as well as stigma and discrimination in healthcare settings are discussed. The article outlines the gaps identified in curricula as well as educational interventions that have been described. As this article was written with a global perspective, the chapter continues with a discussion of the South African legal and policy context, as well as TGD health disparities in South Africa. The final sections in the chapter look at curriculum in the context of medical education, patient experiences of GAHC and the experiences of TGD health professionals providing GAHC.

Chapter 3 Conceptual Framework: I describe PIF as an appropriate conceptual framework for studying the process of how a medical student can become a gender-

affirming practitioner. Individualist as well as social-contextual perspectives of PIF will be discussed.

Chapter 4 Research methodology: provides a rationale for why case study methodology and narrative inquiry as complementary methodological frameworks were best suited for this study. Practical research approaches regarding data generation, data analysis, scientific rigor as well as ethical considerations are also discussed in this chapter.

Chapter 5 Findings for objective 1: Professional Identity formation of a gender-affirming practitioner: The first part of the chapter consists of three research stories from the practitioner group of participants. The second part describes the themes relevant to this objective that were drawn from analysing the research stories.

Chapter 6 Findings for objective 2: Medical curriculum: the first part of the chapter consists of two research stories, chosen from the second group of participants, namely the medical students. The second part describes the themes relevant to this objective, drawn from analysing the research stories as well as the document analysis.

Chapter 7 The case – braiding together: describes the context of the case and further analyses the process of PIF. Aspects of power are discussed from a critical pedagogy perspective.

Chapter 8 Conclusions and new insight: presents the final arguments in this thesis in relation to the key research questions. Suggestions for further research are included.

1.9 Conclusion

In this introduction, I outlined the rationale for the study, with an introduction to the study design and conceptual framework. The next chapter will discuss the literature

from an interdisciplinary perspective as the topic of this study does not neatly fit into one discipline.

Chapter 2 Literature Review

2.1 Introduction to the Chapter and rationale for including a published article

An article published in an international peer reviewed journal, BMC Medical Education, will be included in this chapter (E. De Vries et al., 2020). I am the first author, and my supervisors are the other two authors. This paper gives a detailed rationale for this study, based on a literature review. The article discusses the history of pathologisation of TGD identities, gender-related health disparities experienced by TGD people, as well as stigma and discrimination in healthcare settings. The article then moves on to discuss gender and sexuality in health science education in relation to sexual and gender minority groups, outline the gaps identified in curricula as well as educational interventions that have been described. The argument is made for including TGD health care in curricula and the article concludes that we have an ethical duty as health science educators to include gender-affirming health in health science curricula.

The article links to both objectives for this study. The first objective is to analyse the process of PIF of gender-affirming health care practitioners and students using narrative interviews. The article describes the rationale for training gender-affirming health care practitioners. The second objective is to illuminate how medical curriculum change could enable gender-affirming PIF. The article has a focus on curriculum, discussing both the gaps in teaching about GAHC as well as interventions that have been described.

The article was written with a global perspective. Following the article, I will discuss the South African context as this case study is situated in South Africa. I will review relevant literature that has been published since the literature review for the published article had been completed, as well as expand on the theme of curriculum in health professions education, student experiences of the medical school environment, and patient experiences and perspectives of GAHC. The literature on PIF will be discussed in Chapter 3 (Conceptual Framework).

The topic of this study does not fit neatly into one discipline. Although the main focus is on medical education, aspects of the history of medicine, public health and different clinical disciplines are relevant as well. Transgender healthcare has been described as an interdisciplinary field (Coleman et al., 2022). Interdisciplinarity involves two or more disciplines, with integration of knowledge (Choi & Pak, 2006).

McGaghie (2015) describes “cross-discipline integrative scholarship” as combining research from several fields to illuminate complex questions in medical education and healthcare (McGaghie, 2015, p. 295). From the five different research review traditions that McGaghie outlined, my approach in this literature review is that of narrative review (McGaghie, 2015). This is the most appropriate given the interdisciplinary nature of this study, as I do not have a narrow-focused question for which a systematic review would be suitable. My research question (How can the process of PIF of a gender-affirming practitioner inform medical curriculum change?) includes several different aspects. With a narrative literature review I could integrate the different themes in the literature that are relevant to my question.

2.2 Article

De Vries, E., Kathard, H., & Müller, A. (2020). Debate: Why should gender-affirming health care be included in health science curricula? *BMC Medical Education*, *20*(1), 51. https://doi.org/10.1186/s12909-020-1963-6

Abstract
Background: Every person who seeks health care should be affirmed, respected, understood, and not judged. However, trans and gender diverse people have experienced significant marginalization and discrimination in health care settings. Health professionals are generally not adequately prepared by current curricula to provide appropriate healthcare to trans and gender diverse people. This strongly implies that health care students would benefit from curricula which facilitate learning about gender-affirming health care.
Main body: Trans and gender diverse people have been pathologized by the medical profession, through classifications of mental illness in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Disease (ICD).

Although this is changing in the new ICD-11, tension remains between depathologisation discourses and access to gender-affirming health care. Trans and gender diverse people experience significant health disparities and an increased burden of disease, specifically in the areas of mental health, Human Immunodeficiency Virus, violence, and victimisation. Many of these health disparities originate from discrimination and systemic biases that decrease access to care, as well as from health professional ignorance. This paper will outline gaps in health science curricula that have been described in different contexts, and specific educational interventions that have attempted to improve awareness, knowledge and skills related to gender-affirming health care. The education of primary care providers is critical, as in much of the world, specialist services for gender-affirming health care are not widely available. The ethics of the gatekeeping model, where service providers decide who can access care, will be discussed, and contrasted with the informed-consent model that upholds autonomy by empowering patients to make their own health care decisions.
Conclusion: There is an ethical imperative for health professionals to reduce health care disparities of trans and gender diverse people and practice within the health care values of social justice and cultural humility. As health science educators, we have an ethical duty to include gender-affirming health in health science curricula in order to prevent harm to the trans and gender diverse patients that our students will provide care for in the future.

Keywords: Transgender, Trans and gender diverse, Health disparities, Pathologisation, Gender-affirming health care, social justice, Health science education

Background

Every person who seeks health care should be affirmed, respected, understood, and not judged. However, trans and gender diverse (TGD) people have experienced significant marginalization and discrimination in healthcare settings, as will be described further below. Health professionals are generally not adequately prepared by current curricula to provide healthcare to TGD people and have described feeling “completely out-at-sea” (Snelgrove et al., 2012). This strongly implies that healthcare

students would benefit from curricula which facilitate learning about gender-affirming health care.

The literature search for this debate started with a key word search of databases including Scopus, Medline, Pubmed and Web of Science during the time period 2017–2018. Search terms included ‘trans’, ‘transgender’, ‘medical education’, ‘health science education’, ‘gender-affirming’, ‘curriculum’ and combinations thereof. A search of article reference lists identified further relevant articles as did personal communication with colleagues. This data informed the main topics for this debate. Transgender is a term that refers to persons whose gender identity is different to that normatively expected on the basis of assigned sex. Gender diverse is a term to describe “people who do not conform to society’s or culture’s expectations for men and women” (Oliphant et al., 2018). Non-binary is a term used for a person who identifies as neither male nor female (Deutsch, 2016) and gender nonconforming for a person whose gender identity is different to that normatively expected on the basis of assigned sex, “but may be more complex, fluid, multifaceted, or otherwise less clearly defined than a transgender person” (Deutsch, 2016, p.15). Genderqueer is another term used by some with this range of identities (Deutsch, 2016). For this article, trans and gender diverse (TGD) will be used as an umbrella term to include transgender, gender nonconforming, genderqueer and gender diverse people. Cisgender is a term for someone whose gender identity is the same as that normatively expected on the basis of their assigned sex. Gender-affirming health care has been described by Reisner, Radix and Deutch (Reisner, Radix, et al., 2016, p. S238) as “health care that holistically attends to transgender people’s physical, mental, and social health needs and well-being while respectfully affirming their gender identity”. This is more than just transition-related care and refers to an affirming experience in all health care encounters. Gender-affirming care models utilise an approach of depathologisation of human gender diversity (transgender as ‘identity’), rather than a pathological perspective (transgender as ‘disorder’) (Reisner et al., 2016). Until recently, little gender-affirming research existed, and, in the literature, TGD people have often been included in the broader grouping LGBT. This acronym combines sexual minority people (lesbian, gay, and bisexual people), and gender minority people (TGD people).

These sexual and gender minority groups have in common that they often experience social exclusion, stigma, discrimination, violence, as well as ignorance from health professionals (Ard & Makadon, 2012). These experiences are rooted in societal heteronormativity and cisnormativity that generally marginalises non-heteronormative sexual (LGB) and gender (TGD) identities. Heteronormativity is “the assumption that everyone is heterosexual, and that heterosexuality is superior to all other sexualities” (National LGBT Health Education Center, 2017). Cisnormativity is “the assumption all people are cisgender, that those assigned male at birth always grow up to be men and those assigned female at birth always grow up to be women” (Bourns, 2015). This strong normative facilitates transphobia, which is emotional disgust, fear, hostility, violence, anger or discomfort felt or expressed towards people who do not conform to the gender expectations of society (Psychological Society of South Africa, 2017). Thus, transphobia has been described as a symptom of heterocis-normativity (Worthen, 2016). Müller (2016) comments that though there is a common source of oppression [hetero-cis-normativity], it has to be acknowledged that “this oppression acts on different identities (sexual orientation or gender) in different ways” (Müller, 2016; p. 196). Compared to cisgender people, TGD people experience significant health disparities and an increased burden of disease (Noonan et al., 2018). Many of these health disparities originate from discrimination and systemic biases that decrease access to care, as well as from health professionals’ ignorance (Reisner et al., 2016). It is thus critical to educate health professionals to deliver equitable care for TGD populations, but most health sciences education institutions do not yet provide sufficient education (Holthouser et al., 2017).

Brief history of pathologisation, Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Disease (ICD)

People with diverse gender identities and expressions have been part of society for millennia. With increasing medical interest in providing transition-related care in the 1950’s, the TGD person became a ‘patient’ and with the ‘medical gaze’, diverse gender identities have often been viewed as pathology (Beek et al., 2016). The history of pathologisation is important to understand in relation to gender-affirming health care, as there is a tension between pathologisation and access to health care (Polderman et al., 2018).

Historically, medical research produced the ‘scientific’ evidence that pathologized sexualities and gender identities that did not conform to societal expectations, as well as supported treatments such as so-called “conversion therapy” that is now regarded as unethical (Polderman et al., 2018). Until 1973, homosexuality was listed as a mental illness in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) (King, 2004). Sex between people of the same sex or gender still remains criminalised in 68 United Nations member states in 2019 (Mendos, 2019). The DSM is an influential document that is used internationally to diagnose and classify mental illness. Gender diversity remains listed in the DSM until today. In the DSM-4, the term “Gender identity disorder” was used and in DSM-5 this had been changed to “Gender Dysphoria” (American Psychiatric Association, 2013). The intention of the change in the DSM-5 was to reduce stigma, while ensuring that individuals are able to access the care they need (Beek et al., 2016). Proponents for the term “Gender Dysphoria” argued that it was less stigmatizing than “Gender identity disorder” (Beek, Cohen-kettenis, et al., 2016). However, others have pointed out that gender diversity in itself is not pathological, and have questioned the need to medically classify and diagnose gender diversity (Davy et al., 2018; Kara, 2017). The International Classification of Disease (ICD) of the World Health Organisation (WHO) is used to code diagnoses and process payment for health care, especially in the private health care sector. It includes diagnoses for all body systems, whereas the DSM only categorises mental illness. In 1975, a diagnosis of “transsexualism” was introduced in the ICD-9 (Beek et al., 2016), and in the ICD-10, published in 1992, the diagnostic term was changed to “Gender Identity Disorder” (World Health Organization (WHO), 1992). In the ICD–11, this term will be changed to “Gender Incongruence” (Beek et al., 2016). It will be relocated from the chapter on Mental and Behavioural Disorders to a new chapter, Conditions Related to Sexual Health. On 18 June 2018, the WHO published a version of ICD-11, with the press release stating “While evidence is now clear that it is not a mental disorder, and indeed classifying it in this way can cause enormous stigma for people who are transgender, there remain significant health care needs that can best be met if the condition is coded under the ICD” (World Health Organization (WHO), 2018). The ICD-11 was adopted at the World Health Assembly on 25 May 2019, for implementation in 2022 (World Health Organisation, 2019).

While such a diagnostic classification might be needed in order to access gender-affirming treatment, it is the view of many TGD activists and groups that it can further pathologize and stigmatise TGD identities (Drescher et al., 2012; Müller, 2016).

Although a strong argument has been made towards depathologisation, including in Southern Africa (Kara, 2017), some in the Southern African TGD community have also raised concerns regarding the depathologisation movement (McLachlan, 2019). McLachlan (2019, p. 11) argues that "the African context may be more sympathetic towards a person who has a diagnosis and is identified as having a mental condition than a person who diverges from what is seen and/or constructed as the norm". This remains a controversial topic with many different perspectives, ranging from no diagnostic category at the one end of the spectrum, to the middle ground of a diagnosis of "gender incongruence" in a separate chapter in the ICD-11, to retention as a mental health diagnosis as in the current DSM-V. Tensions continue to exist over how to classify "gender incongruence" to both depathologise gender diversity expressions and identities, while ensuring access to gender-affirming health care (Polderman et al., 2018). Regardless of if or how gender incongruence is classified within (or without) medical classification systems, TGD people have the right to receive health care that is affirming, respectful and non-judgmental, for which health professionals play a crucial role.

Do TGD people experience gender-identity related health disparities?

Social determinants of health (SDOHs) are defined by the WHO as "the conditions in which people are born, grow, live, work and age" and that are "shaped by the distribution of money, power and resources." (World Health Organisation, 2017). Pega and Veale argue for the recognition of gender identity as a SDOH (Pega & Veale, 2015).

> Prejudice, stigma, transphobia, discrimination, and violence targeted at TGD people produce differential levels of social exclusion for populations defined by gender identity, including in health care settings. These social conditions disadvantage TGD people through social exclusion and privilege cisgender people through social inclusion, resulting in differential health outcomes. So, although gender identity in itself does not determine health, it socially stratifies the population into differential exposures to SDOHs such as transphobia" (Pega & Veale, 2015, p. e59).

This can be compared to other social stratifiers such as race or ethnicity, which are also considered SDOHs (Pega & Veale, 2015).

The health disparities are not inherent to TGD individuals but stem from structural factors such as government policy and hostile health care environments, as well as community and interpersonal factors such as social discrimination and rejection by families (Reisner, Poteat, et al., 2016). Such structural, community and interpersonal factors can contribute to a delay in accessing gender-affirming care (Donald et al., 2017; Seelman et al., 2017). TGD people who belong to racial and ethnic minority groups face even more challenges (Kattari et al., 2015). Intersectionality acknowledges that identity is multidimensional and is impacted on by historical, structural, and cultural factors (Eckstrand et al., 2016; Ng, 2016). Ng eloquently explains that "Practicing medicine through the lens of intersectionality proactively considers patients' diverse identities and how the sociocultural factors associated with membership in multiple minority groups can affect their health risks and health care experiences, and ultimately health decision making and health outcomes" (Ng, 2016, p. 325). It is thus important to keep in mind that despite a shared marginalised identity, TGD people are not a homogenous group, and that sub-groups and individuals may have different healthcare needs.

There are specific areas in which gender identity related health disparities have been researched. In the section that follows, we will discuss mental health, Human Immunodeficiency Virus (HIV), violence and victimisation. This evidence on health disparities shows that there are specific gender identity-related issues that health professionals need to know about and that should be included in health science curricula.

Mental health

A review of the health burden and needs of TGD populations globally reports that there is a significant mental health burden (Reisner, Poteat, et al., 2016). For example, estimates of depression prevalence were as high as 63% in a United States of America (USA) sample of 230 TGD women (Nuttbrock et al., 2013). An Australian survey of 859 TGD young people found that 74.6% of participants had a

diagnosis of depression and 72.2% an anxiety disorder (Strauss et al., 2017). In this study, the incidence of self-harm was 79.7%, and 48.1% of participants reported a suicide attempt in the past (Strauss et al., 2017). The authors point out that “the higher frequency of mental health difficulties than the general population is not because an individual identifies as TGD. Rather, these difficulties are largely caused by external factors – in other words, how the world perceives and treats transgender people” (Strauss et al., 2017, p. 12). To make sense of the high rate of attempted suicides by TGD people, experiences of rejection and discrimination need to be considered as a key factor (Klein & Golub, 2016). Meyer has described the concept of minority stress in LGB persons — explaining that “stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems” (Meyer, 2003, p. 674). Hendricks and Testa framed minority stress as a concept in TGD people (Hendricks & Testa, 2012), by applying the factors described by Meyer: “prior discrimination or victimization, expectations of future victimization or rejection, internalized transphobia, and resilience” (Hendricks & Testa, 2012; Meyer, 2003). Firstly, the external events that impact on someone’s life as a result of their minority status such as discrimination and threats to their safety can negatively affect their mental health. The second factor is the anticipation and expectation that external stressful events will occur, leading to heightened vigilance. The negative expectations themselves can create distress for the person. The third factor is internalized transphobia, which can negatively affect someone’s ability to cope with external stressful events and ultimately reduces their resilience. This resonates with the description of TGD stigma by White Hughto et al., (2015) as operating at structural, interpersonal and individual levels. Importantly, Meyer (2003) points out that not all of the effects of minority stress are negative, as members of minority groups can develop resilience. Hendricks and Testa (2012) describe “group-level coping” in TGD persons, when they engage with other members of their minority group (Hendricks & Testa, 2012, p. 465). Trans-specific social networks can create a supportive community that can buffer the effects of discrimination and violence. Riggs and Treharne (2017) add the theoretical framework of decompensation, described as “[ceasing] being able to compensate, [ceasing] being able to make up for the daily discrimination, [ceasing] being able to prop oneself up in the face of ideologies that render one’s existence unintelligible” (Riggs & Treharne, 2017, p. 600). This framework emphasises the need to challenge ideology

and social norms that cause decompensation, as opposed to only focusing on individual resilience (Riggs et al., 2015; Riggs & Treharne, 2017). Unfortunately, due to the lack of health professionals' knowledge, and implicit or explicit prejudicial attitudes, the healthcare system often perpetuates the discrimination and marginalisation of TGD people within wider society, and this environment adds to, rather than alleviates, gender identity-related minority stress (Jacob & Cox, 2017). A study that compared the mental health of socially transitioned TGD children who are supported in their gender identity to that of cisgender children, found that depression rates were similar in both groups, and only slightly elevated anxiety rates were found amongst the TGD children (Olson et al., 2016). Social transition can thus be regarded as a buffer against poor mental health. While there is a high prevalence of mental health challenges, there is evidence that gender-affirming hormone treatment can improve mental health (Costa & Colizzi, 2016; Keo-Meier et al., 2015; Wilson et al., 2015).

HIV

TGD women are disproportionately affected by HIV and other sexually transmitted infections (Reisner et al., 2016). A systematic review reported an odds ratio of 48.8 for HIV infection in TGD women compared with all adults of reproductive age across 15 countries (Baral et al., 2013). A study of 230 TGD women in New York found that "gender abuse predicted depressive symptoms, and gender abuse combined with depressive symptoms predicted both high-risk sexual behaviour (unprotected receptive anal intercourse) and HIV" (Nuttbrock et al., 2013, p. 300).

Violence and victimisation

A high burden of violence and victimisation experiences in TGD people have been documented in research across the globe (Reisner et al., 2016). A WHO review reported that a high proportion of gender minority people experienced physical and sexual violence, motivated by bias or hate based on their gender identity (Blondeel et al., 2018). This review found that "the prevalence of physical violence in TGD people ranged from 11.8% to 68.2% and sexual violence 7.0% to 49.1%" (Blondeel et al., 2018, p. 29). A comparative study on being TGD in Europe that included 28 countries, analysed data from 6579 respondents (European Union Agency for Fundamental Rights, 2014). While 54% of respondents stated that they had been

discriminated against during the last year, 22% felt discriminated against in a health care setting (European Union Agency for Fundamental Rights, 2014). A study of the effect of violence on TGD people, with a sample of 179 TGD women and 92 TGD men in Virginia found that those who had experienced physical and/or sexual violence were significantly more likely to report a history of suicide attempts, alcohol abuse and illicit substance use (Testa et al., 2012). TGD individuals who present visibly as gender nonconforming have been shown to face even more discrimination compared to their gender conforming counterparts (Miller & Grollman, 2015), and a UK study found that respondents currently undergoing a process of transition were significantly more likely to have reported experiencing physical and sexual harassment, compared to those who were proposing to undergo or had already undergone a process of transition (Ellis et al., 2016). In a survey of attitudes towards homosexuality and gender non-conformity in South Africa, 1% of respondents (n = 3079) agreed to the statement "I have physically hurt women who dressed and acted like men in public in the past year", and between 6.2 and 7.4% of South Africans indicated that they might use violence against gender non-conforming people in the future (Sutherland et al., 2016). Violence towards trans people is not only institutional and societal, but can be experienced within families, as described by Rogers who found that family perceptions of shame and stigma can lead to transphobic 'honour-based' abuse (Rogers, 2017).

Do TGD people experience stigma and discrimination in health care settings?

TGD persons are more likely to face barriers when they try to access appropriate health care, compared to their cisgender peers (Müller, 2017). There is evidence in the literature that transphobia in the health sector can lead to experiences of discrimination and stigma. Several USA studies of TGD persons reported negative health care experiences and found that knowledge gaps and discrimination contributed to a disparity in health care delivery (Grant et al., 2011; Jaffee et al., 2016; James et al., 2016; Kosenko et al., 2013; Samuels et al., 2018). A Canadian study of 923 TGD youth found that they described many past negative care encounters, with "uncomfortable and frustrating encounters with doctors" (Clark et al., 2017). Two qualitative Swedish studies (Lindroth, 2016; von Vogelsang et al., 2016) found that TGD persons experience estrangement in health care settings, due to lack of knowledge among health professionals. Participants described being

treated as different, “to be regarded as a monkey in a cage appears to be very strenuous” (von Vogelsang et al., 2016). In a UK study, 29 % of respondents (n = 411) felt that their gender identity was not validated as genuine in mental health settings and qualitative data indicated that some trans people felt that at gender identity clinics, the clinical sessions “ran counter to the preservation of their dignity and human rights” (Ellis et al., 2016). Negative experiences of gender diverse Australians were reported as physical healthcare being “invasive and sometimes abusive” (Riggs et al., 2014).

There is limited research about TGD people published from the African continent and Asia. Qualitative studies in South Africa have reported that many of the TGD persons interviewed had experienced health workers as being discriminatory and hostile (Newman-Valentine & Duma, 2014; Sanger, 2014; Stevens, 2012). Negative health care experiences can be the result of subtle, apparently insignificant features of health care spaces and interpersonal interactions called microaggressions (Dean et al., 2016; Nadal et al., 2016). Nadal et al. define microaggressions as “subtle forms of discrimination, often unconscious or unintentional, that communicate hostile or derogatory messages, particularly to and about members of historically marginalized social groups” (Nadal et al., 2016, p. 488). Although originally used to describe racial microaggressions (Sue et al., 2007), the theory was expanded to include other marginalised groups, including TGD people (Nadal et al., 2016). Health care spaces and providers often convey cisnormative microaggressions, which communicate to TGD people that “their identities, experiences, and relationships are abnormal, pathological, unexpected, unwelcome, or shameful” (Dean et al., 2016, p. 557). An example would be misgendering, a term meaning patients were misidentified or referred to by the incorrect pronoun (Nadal et al., 2012).

Gender and sexuality in health science education in relation to sexual and gender minority groups

Much of the negative attitudes of health professionals toward sexual and gender minority groups may originate from wider societal homophobia and transphobia. The paucity of education about LGBTQ health allows these notions to go unchallenged, thereby maintaining the heteronormative and cisnormative culture in health facilities (Meer & Müller, 2017). In health sciences, the dominant pedagogical approach to

sexuality has been biomedical. This emphasis leaves little space to interrogate the constructions of gender and sexuality through social dynamics (Bennett & Reddy, 2007). Müller & Crawford-Browne (2013) argue that "biomedical discourse bases its authority on empirical evidence – 'objective' scientific facts – and constructs people's bodies as results of biological processes and determinations" (Müller & Crawford-Browne, 2013, p. 26). This biomedical approach makes it difficult to situate these bodies in their social context. Although more emphasis has been placed in recent years on the biopsychosocial approach, the health sciences have traditionally regarded bodies through a positivist lens that limits the extent to which socially constructed identities can be acknowledged (Müller & Crawford-Browne, 2013). It is essential for health sciences education to include critical reflection on the historical and contemporary hegemony of heteronormative and cisnormative discourses. This can assist both students and teachers to identify their discomfort with LGBTQ patients and reflect on how this could have originated in oppressive structures (Harbin et al., 2012). This can begin to address the root causes of the alienation experienced by TGD persons in health care settings, rather than just treating the symptoms.

What are the gaps in curricula?

Several studies have been published internationally that describe the gaps in medical curricula. In a study of undergraduate medical education in the USA and Canada in 2009–2010, only 30.3% of the 150 medical schools surveyed reported teaching about gender transitioning (Obedin-Maliver et al., 2011). Gaps in residency programs in the USA have been described for Emergency Medicine (Moll et al., 2014), Urology (Dy et al., 2016) and Plastic surgery (Morrison et al., 2017). A survey of 15 Australian and New Zealand medical schools found that teaching about gender and gender identity is varied across schools, with seven respondents (47%) unsure about what is taught (Sanchez et al., 2017). In a United Kingdom study of medical students, participants were particularly unconfident on TGD health terminology and 72.9% felt "very unconfident" or "unconfident" deciding into which ward TGD patients should be admitted (Parameshwaran et al., 2017). Canadian qualitative studies found a reported lack of knowledge regarding TGD health among family physicians (B. Beagan et al., 2015) and mental health care providers (Rutherford et al., 2012). A Canadian qualitative analysis of physician-side barriers to providing health care for

TGD patients aptly titled “Completely out-at-sea with two-gender medicine”, found that a lack of knowledge made the clinical management of TGD patients more complicated (Snelgrove et al., 2012). In a survey of emergency medicine physicians in the USA, 82.5% reported that they did not receive formal training on TGD health care although 88% reported caring for this population (Chisolm-Straker et al., 2018). A study of speech-language pathologists in four countries found that although TGD communication is within their scope of practice, 47% of respondents indicated that this was not included in their master’s curriculum (Hancock & Haskin, 2015). A study of health professions education in South Africa and Malawi (Müller et al., 2017) found that there is little formal inclusion of LGBTQ health topics in nursing and medical curricula, and that educators who do teach LGB health topics reported doing so because “they felt personally compelled to include them”, not because this was supported or mandated institutionally (Müller et al., 2017, p. 29). Topics related to TGD health and differences in sex characteristics were not covered by any of the participating educators (Müller et al., 2017).

An ethical discussion by Tomson (Tomson, 2018) that compares the gatekeeping model and the informed-consent model of providing gender-affirming care provides an important perspective of how lack of knowledge of health professionals can lead to unethical care. In the gatekeeping model, service providers make the assessment of whether or not a patient should be allowed access to gender-affirming care. Tomson argues that this violates the principle of respect for autonomy (Tomson, 2018). In contrast, the principle of autonomy is upheld by the informed-consent model. In this model, treatment is a cooperative effort between the patient and provider where well-informed patients are the primary decision makers about their care (Cundhill et al., 2017). A patient’s ability to make informed decisions about their health, e.g., starting hormone treatment, is enhanced by thorough education (Cundhill et al., 2017). Furthermore, Tomson argues that “since access to medical transition improves outcomes (particularly suicide risk) for TGD patients, limiting access to these interventions can be seen as harmful in and of itself, and as such, is a violation of the principle of non-maleficence” (Tomson, 2018, p. 26). When patients can decide on their own health care in an informed consent model, without factors such as race, social class or finance creating barriers to access, this promotes equity and fairness and upholds the principle of justice (Tomson, 2018). Although the

informed consent model is used in some clinics (Deutsch, 2012), the gatekeeping model is still the mainstream treatment paradigm in many settings (Schulz, 2018), which has implications for the role of health science education to promote an ethical model of care.

What educational interventions have been described?

A recent scoping review of improving medical students' and residents' training and awareness of TGD health care found that consensus is lacking on exactly which educational interventions to use to address this topic (Dubin et al., 2018). Another review focusing on curricular initiatives that enhance student knowledge and perceptions of sexual and gender minority groups concluded that "multi-modal approaches that encouraged awareness of one's lens and privilege in conjunction with facilitated communication seemed the most effective" (Desrosiers et al., 2016). The literature supports a shift toward longitudinally integrated and clinical skills based pedagogical interventions (Dubin et al., 2018). A 90 min workshop for psychiatry residents at Columbia university, USA, produced significant short-term increases in resident professionalism toward TGD patients (Kidd et al., 2016). However, on 90-day follow-up, this study did not find any statistically significant differences in perceived empathy, knowledge, comfort, and motivation for future learning, compared to baseline (Kidd et al., 2016). This highlights the limitations of one-time interventions and call for longitudinal programming to produce more durable improvements. Stroumsa et al. (2019) caution that transphobia needs to be addressed specifically as a potential barrier to improved knowledge (Stroumsa et al., 2019). Their study did not find any association between increased hours of education and improved knowledge but found a negative association between transphobia and provider knowledge (Stroumsa et al., 2019). Gamble Blakey and Treharne (2019) emphasize values cultivation as a starting point in educating about TGD healthcare and argue that simply adding curricular content about gender-affirming care may not result in significant learning as this requires a sensitive and specific pedagogic discourse around values (Gamble Blakey & Treharne, 2019).

The Association of American Medical Colleges published an extensive resource for medical educators in 2014, titled "Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender

Nonconforming, or Born with DSD" (Association of American Medical Colleges, 2014). It discusses the role of medical education and health care professionals in eliminating health disparities, lists professional competency objectives as well as discusses integrating competencies into medical school curricula (Association of American Medical Colleges, 2014). This publication has been described by Donald et al. as "representing a new frontier in medical education that attempts to redefine health to be inclusive of sexual orientation, gender identity, gender expression, and sex development—four intrinsic components of personhood" (Donald et al., 2017, p. 346). In the chapter on Trauma and Resilience, the authors emphasize that competence in providing care to diverse individuals requires more than an understanding of the causes of health disparities and to know to avoid microaggressions, making assumptions or discriminatory remarks:

> It is imperative that health care providers learn how to promote resilience in the lives and families of individuals who are members of these groups so as to mitigate the effects of real and perceived trauma on risk behaviours and adverse health outcomes (Association of American Medical Colleges, 2014, p. 38).

There has been a recent proliferation of publications in professional journals to educate medical practitioners already in practice. These include the specialities of Endocrinology (Hembree et al., 2017), Paediatrics (A. L. C. de Vries et al., 2016; Lopez et al., 2017; Rafferty, 2018); Family Medicine (Klein et al., 2018; Stumbar, 2018), Gynaecology (Unger, 2014), Psychiatry (Wylie et al., 2014), Surgery (Berli et al., 2017; Salibian et al., 2018) and Anaesthesia (Tollinche et al., 2018). Free e-learning courses have been developed such as "Primary Health Care for Trans, Gender Diverse & Non-binary People" (McNair & Andrews, 2019) and "Caring for Gender Nonconforming young people" (GIRES, n.d.).

Argument for including TGD health care in curricula

Winter argues that because "primary care is the most common point of contact that TGD people have with the health system, effective training for primary care providers through medical education and continuing professional development, is needed" (Winter et al., 2016, p. 318). Primary care providers can evaluate gender dysphoria and manage applicable hormone therapy (Klein et al., 2018). In much of the world, specialist services for gender-affirming health care are not widely available, which

reinforces the need for the training of primary care providers. DasGupta and colleagues argue that incorporating social justice into the education of medical professionalism is critical (DasGupta et al., 2006). A global consensus document on the social accountability of medical schools (Boelen, 2010) includes statements that resonate with the need to include gender-affirming health in curricula, such as: “The medical school recognizes the various social determinants of health – and directs its education, research and service delivery programs accordingly,” and “the medical school recognizes the local community as a primary stakeholder and shares responsibility for a comprehensive set of health services to a defined population in a given geographical area, consistent with values of quality, equity, relevance” (Boelen, 2010 p. 4). A South African report, “Reconceptualising Health Professions Education in South Africa” states that “the ultimate goal of health professions education is to produce knowledgeable, competent, relevant, socially accountable health care professionals capable of confidently and collaboratively promoting health and addressing the country’s burden of disease across the continuum of health care in the context of quality universal health coverage” (Academy of Science of South Africa, 2018, p.33). To be socially accountable, medical educators need to include the health needs of TGD people in medical curricula (Bonvicini, 2017; Donald et al., 2017). The ethical imperative of the medical profession to reduce health care disparities and practice within the health care values of social justice, cultural humility and humanism has been highlighted by medical educators and researchers (Association of American Medical Colleges, 2014). The World Medical Association (WMA) adopted a statement on TGD people in 2015 (World Medical Association, 2015). In this document, the WMA calls “for the provision of appropriate expert training for physicians at all stages of their career to enable them to recognise and avoid discriminatory practises, and to provide appropriate and sensitive transgender health care” (World Medical Association, 2015, p. 3).

Conclusion

Whereas ideally gender should be viewed as a spectrum, and gender diversity as part of the diversity of humanity, in reality TGD persons often have very difficult lives due to not fitting into society’s cisnormative expectations (Noonan et al., 2018; Reisner et al., 2016). This leads to significant gender identity-related health disparities in the areas of mental health (Nuttbrock et al., 2013; Strauss et al., 2017),

HIV risk (Baral et al., 2013), as well as violence and discrimination (Blondeel et al., 2018). TGD people often experience stigma and discrimination in health care settings, which is a barrier to access to care (Müller, 2017). Health professional attitudes and knowledge gaps contribute to and exacerbate these health disparities (Grant et al., 2011; Jaffee et al., 2016). The minority stress model describes how external stressors such as transphobic experiences can lead to anticipation of bad experiences, which can lead to avoidance of accessing health care (Hendricks & Testa, 2012; Meyer, 2003). Several studies have described the gaps in undergraduate medical training (Obedin-Maliver et al., 2011; Parameshwaran et al., 2017; Sanchez et al., 2017) as well as residency training (Dy et al., 2016; Moll et al., 2014; Morrison et al., 2017). The gatekeeping model, where service providers decide who can access care, violates the ethical principle of respect for autonomy, while the informed-consent model upholds autonomy by empowering patients to make their own health care decisions (Tomson, 2018). As health science educators, representing a profession that has pathologized (Drescher et al., 2012; Müller, 2016), and continues to pathologize TGD identities (Polderman et al., 2018), we have an ethical duty to include gender-affirming health in health science curricula (Association of American Medical Colleges, 2014; Bonvicini, 2017; World Medical Association, 2015) in order to prevent harm to TGD patients that our students will provide care for in the future.

2.3 South African context

2.3.1 South African Legal and Policy context

In South Africa, the legal and policy context supports the rights of transgender persons, although that is often very different from their lived realities (Hamblin & Nduna, 2013; Newman-Valentine & Duma, 2014). The Bill of Rights in the South African Constitution (Constitution of the Republic of South Africa, 1996), section 9 is clear about the right to non-discrimination. Section 10 guarantees that “everyone has inherent dignity and the right to have their dignity respected and protected” (Constitution of the Republic of South Africa, 1996, p. 6). The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 gives effect to Section 9 of the Constitution, so as to prevent and prohibit unfair discrimination and harassment (Republic of South Africa, 2000). Section 27 of the South African constitution

(Constitution of the Republic of South Africa, 1996) states that everyone has the right to have access to health care services. This means that we are constitutionally obliged to practice gender-affirming health care.

The Health Professions Council of South Africa (HPCSA)'s core ethical values and guidelines for good practice state that health professionals should ensure that "their personal beliefs do not prejudice their patients' health care" (Health Professions Council of South Africa, 2016a, p. 5). Gender and sexual orientation are specifically named as examples in which the treatment of a patient might be affected by a health professional's personal beliefs (section 5.1.5, p. 5). The HPCSA guidelines thus indicate that doctors have an ethical obligation to treat LGBTI patients in a manner that is non-discriminatory and non-judgemental, regardless of their own personal attitudes and beliefs (Health Professions Council of South Africa, 2016a).

In South African health care, in recent years there has been a shift to include LGBT health into health care policy recommendations. Transgender people were identified as one of the most-at-risk populations in the 2012–2016 National Strategic Plan for HIV, STIs and TB (SA National Department of Health, 2011). In the subsequent 2017-2022 Strategic plan, transgender people are identified as one of the key populations and Goal 3 is stated as "Reach all key and vulnerable populations with customised and targeted intervention services" (SANAC, 2017). The 2023-2028 plan has specific goals regarding transgender persons, such as "Inclusion of gender affirmation package of services at all levels of care, transgender-friendly facilities in all service settings, and access to comprehensive mental health and psychosocial support" (National Department of Health, 2023, p. 65). Even though TGD people may be a minority, it is an important group that needs to be prioritised as part of a comprehensive medical approach.

The Psychological Society of South Africa (PsySSA) published guidelines for working with sexually and gender diverse people in 2017 (Psychological Society of South Africa, 2017). This was a landmark publication, that was a first for Africa and specifically focused on the South African context (McLachlan et al., 2019).

In October 2021, the SA HIV Clinicians Society published the first Gender-affirming Guideline for South Africa (Tomson et al., 2021). This was developed to have a guideline relevant for the South African context, and to facilitate access to GAHC that is sensitive, skilled, and respectful. The values underpinning the guideline are described, with chapters discussing the different aspects of GAHC. It is grounded in a strong human rights framework and in the development, the voices of TGD persons were foregrounded. A value that stands out is "trans giftedness" which recognises that TGD persons have unique perspectives and insights, and advocates for a strength-based perspective rather than condescending to or pitying TGD persons (Tomson et al., 2021). This guideline has become an important resource for training in GAHC in South Africa. To date there is no guideline from the National Department of Health for GAHC.

2.3.2 Health disparities in South Africa (Mental Health, HIV, Violence and Discrimination)

The published article discussed health disparities and experiences of accessing healthcare from a global perspective. This section will look at South African literature on mental health, HIV, violence, and discrimination. In 2019, a report was published of a study in 9 African countries, called "Are we doing alright? Realities of violence, mental health and access to healthcare related to sexual orientation and gender identity and expression" (Müller et al., 2019). In the South African TGD respondents' group (n=232), mental health challenges were identified as follows: depression 63%, anxiety 39%, suicidal ideation in the past year 36%, (lifetime 67%) and suicide attempts in the past year 16% (lifetime 46%). This is comparable to the high prevalence reported internationally (Nuttbrock et al., 2013; Reisner et al., 2016; Strauss et al., 2017).

Regarding HIV prevalence, the Botshelo Ba Trans study reported that the HIV prevalence among transgender women in 3 cities in South Africa is 46% (Cloete et al., 2023), compared to a prevalence in the general population of 14% (Zuma et al., 2022). This is much higher than the worldwide prevalence in transgender women, which has been reported in a systematic review and meta-analysis as 19.9% (Stutterheim et al., 2021). Multiple sociocultural and structural barriers negatively

affect access to HIV care for transgender women, contributing to adverse HIV outcomes (van der Merwe et al., 2020).

Very high violence figures are reported in the Müller et al. (2019) study in which 27.01% of gender minority South African respondents experienced physical violence due to their gender identity in the past year, with a 61.21% lifetime prevalence. The sexual violence figures are very concerning, with a lifetime prevalence of 62.15% and 28.91% in the past year (Müller et al., 2019). The sexual violence figures are higher than the WHO review which reported a range of 7.0% to 49.1% (Blondeel et al., 2018).

Stark experiences of stigma and discrimination in health care settings have been documented in South Africa. In the study by Müller et al. (2019), 39% of gender minority respondents reported that they had been denied healthcare because of their gender identity (Müller et al., 2019). The 2023 Ritshidze Key Population report states that 9% of TGD respondents had been refused access to health services (Treatment Action Campaign et al., 2023). Of TGD respondents who do not access health services at all (n=96), the reasons were reported as: staff are not friendly (49%); privacy is not respected (44%) and respondents don't feel safe (27%) (Treatment Action Campaign et al., 2023).

2.4 Recent literature on including GAHC in medical curricula

Since the publication of the article included in the first part of this chapter, there has been an increase in publications identifying gaps in curricula, describing interventions, and suggesting strategies on how to include GAHC in curricula. Furthermore, the international guideline for GAHC, the WPATH Standards of Care 8 (Coleman et al., 2022), includes a chapter on Education for the first time. The chapter recommends that "all members of the health care workforce receive cultural-knowledge training focused on treating transgender and gender diverse individuals with dignity during orientation and as part of annual or continuing education" (Coleman et al., 2022, p. S28). It further recommends differentiated training by each of the specialities: "institutions involved in the training of health professionals develop competencies and learning objectives for transgender and gender diverse health

within each of the competency areas for their specialty" (Coleman et al., 2022, p. S29).

A scoping review on Transgender Medical Education by Nolan et al. (2020) found an expanding variety of educational interventions, with an increase in interdisciplinary, longitudinal, and post-residency approaches (Nolan et al., 2020). The authors comment that while consensus on the importance of GAHC may be emerging, there is a variety of pedagogical approaches, which precludes identifying best practices (Nolan et al., 2020).

A qualitative study in Canada identified transphobia as a specific barrier to accessing quality GAHC (McPhail et al., 2016). The authors state that education that only focuses on knowledge gaps without addressing transphobic attitudes, is unlikely to be effective They agree with Baker and Beagan (2014) that cultural humility is important, to give students the opportunity to reflect on their beliefs about gender normativity (Baker & Beagan, 2014; McPhail et al., 2016).

A qualitative study in New Zealand explored the perspectives of both teaching staff from health professional education programmes and transgender community members on the best ways to teach about GAHC (Treharne et al., 2021). Although teaching staff communicated a strong awareness of the need for teaching about GAHC, they expressed feeling that they are lacking the expertise and have gaps in their knowledge and understanding. Transgender community members who participated said that they were willing to be involved in teaching, but not all TGD people will be comfortable. In addition, they can only describe their own experience which is not representative of the diverse TGD community. The issue of safety of community members in group discussions with students was raised, which will require expertise from educators (Treharne et al., 2021).

Ellaway et al. (2022) published the findings of a Delphi study in Canada to develop an undergraduate medical curriculum framework for providing care to TGD patients (Ellaway et al., 2022). This curriculum framework outlines core values, core teaching objectives, as well as teaching principles. The core values include that training should "be focused on primary care and broad skills applicable to all specialties;

emphasize relationship building and patient experience; emphasize the importance of patient advocacy and communication; and be inclusive of all trans, non-binary and gender diverse identities and presentations" (Ellaway et al., 2022, p. 41). The core teaching objectives are extensive and are outlined under the following headings: Language and Terminology; History, Epidemiology, Social Determinants of Health; Mental health; Hormones; Surgery; and Sexual and Reproductive Health (Ellaway et al., 2022).The framework emphasises the inclusion of community members in training activities, but also raise the point about safety as previously mentioned (Treharne et al., 2021).

In 2021, the WHO Bulletin published recommendations on Transgender health in medical education (Hana et al., 2021). The article recognises that a multipronged approach is needed to improve access to care for TGD people. This includes education of clinicians in GAHC; policy change in health-care institutions; and systemic advocacy to address the SODH. Key elements for comprehensive education on transgender health in medical schools were identified as:
cultural humility and anti-oppression training; involvement of community members; longitudinal integration throughout medical school curricula; practice-focused training; staff development and improving access to careers in medicine for TGD people (Hana et al., 2021).

The argument for longitudinal integration into the curriculum has been convincingly made (MacKinnon et al., 2021). The authors use the analogy of an island to describe isolated training on GAHC: "The island model of teaching and learning thereby amplifies the 'othering' of gender minority patients within health professions education, phenomena that also affects trans learners themselves" (MacKinnon et al., 2021, p. 199). They recommend constructing integrated instruction that highlights the cause-and-effect relationships between relevant procedural and conceptual knowledges, for example when learning how to make decisions about hormone therapy (procedural knowledge), students should also learn why this practice relates to fundamental concepts of informed consent (conceptual knowledge) (MacKinnon et al., 2021).

In summary, international publications emphasise the importance of including GAHC in curricula (Coleman et al., 2022; Nolan et al., 2020). An undergraduate curriculum framework has been published (Ellaway et al., 2022), with key elements having been identified such as longitudinal integration and involvement of members of the TGD community (Hana et al., 2021; Treharne et al., 2021).

2.5 Curriculum

The literature review will briefly discuss curriculum in the context of medical education, the concept of 'hidden curricula' and curriculum change. I acknowledge that 'curriculum studies' is a whole field on its own and I will only have a specific focus for this study.

2.5.1 What is curriculum in the context of medical education?

The word curriculum has its roots in the Latin word for track or racecourse (Prideaux, 2003). From there it came to mean course of study or syllabus. Today the definition is much wider and includes all the planned learning experiences of a school or educational institution (Prideaux, 2003). There are different definitions of curriculum. The British General Medical Council defines curriculum as follows:

> A curriculum is a statement of the intended aims and objectives, content, experiences, learning outcomes and processes of a programme or course of learning, including a description of the structure, and expected methods of learning, teaching, assessment, feedback and supervision. The curriculum should set out a programme of learning and specify what learning outcomes the learner will achieve. How these outcomes will be assessed through a coherent programme of assessment and how learners will be determined as having successfully completed a programme of learning must also be described" (General Medical Council, 2017, p. 32).

Jakes Gerwel defined curriculum as the "interlinked complex of who is taught, what is taught, how it is taught, who teaches, and within what context we teach" (Gerwel, 1991, p. 10). Therefore, what is taught (the syllabi), who teaches (the professional educators), how it is taught (the teaching and learning process), to whom teaching occurs (the learners) and the context of teaching are factors which are regarded as basic to the concept of curriculum (Pillay et al., 1997). I find this to be a practical

definition, that looks more broadly than what is documented in a statement, bringing in the human aspect.

According to the curriculum of practice conceptual framework described by Pillay, Kathard & Samuel (1997), there are three perspectives, namely the official perspective (written down); the espoused perspective (what professionals claim they actually do) and the actual perspective (what actually happens in the workplace) (Pillay, M et al., 1997). Pentecost et al (2018) describe a gap between "i) the intentions of programme planners (the espoused curriculum); ii) the learning and assessment opportunities that educators create for students (the enacted curriculum) and iii) the manner in which students engage in educational activities (the experienced curriculum)" (Pentecost et al., 2018, p. 226). This is conceptually useful for me, to think about the intended (espoused), enacted and experienced curriculum.

Competency-based medical education (CBME) is a curricular concept focusing on teaching skills, rather than a static, prefabricated collection of knowledge (Frank et al., 2010). Potential shortcomings of CBME have been described. This includes reductive approaches like creating highly detailed checklists of skills, which can lead to students focusing on the achievement of milestones, rather than achievement of independent competent practice as the ultimate goal in medicine (Talbot, 2004). A South African report, "Reconceptualising Health Professions Education in South Africa" recognises the shortcomings of CBME and recommends a hybrid competency-based education model that emphasises the process of learning and the achievement of learning outcomes (Academy of Science of South Africa, 2018). Despite the widespread implementation of CBME, there are growing concerns about the translation of physician roles into "measurable competencies" (Jarvis-Selinger et al., 2012). It has been argued that by breaking medical training into discrete, measurable tasks, the medical education community may have emphasised assessment at the cost of a focus on the underlying meaning of physician roles and how future physicians are shaped (Jarvis-Selinger et al., 2012). Hence, they argue for an expanded approach that includes a focus on professional identity development (PIF) (Jarvis-Selinger et al., 2012). Including identity development alongside competency acquisition allows for a reframing of approaches to medical education away from an exclusive focus on "doing the work of a physician" toward a broader

focus that also includes "being a physician" (Jarvis-Selinger et al., 2012, p. 1185). Authors such as Wald (2015) ask:

> As responsible educators, how do we best design standardized and personalized curricula to accompany, guide, support, and challenge our learners on the developmental professional identity (PI) pathway, one with active construction, deconstruction, and reinterpretation processes for healthy PIF consolidation along the way? (Wald, 2015, p. 701).

As an aspect of CBME, cultural competence education has been included in health sciences curricula internationally (Paul et al., 2014). Medical anthropologists have critiqued the notion of cultural competency for portraying culture "as a static entity in which health professionals can be trained to develop expertise" (Baker & Beagan, 2014, p. 581). There has been a movement from the use of the term "cultural competency" to that of embracing cultural humility (Foronda et al., 2014). "Cultural competency" makes the assumption that one can be competent in understanding another culture, which may lead to stereotyping (Tervalon & Murray-García, 1998; Yancu & Farmer, 2017). Tervalon and Murray-García (1988) conceptualise cultural humility as a process, by:

> a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations (Tervalon & Murray-García, 1998, p. 123).

It emphasizes understanding one's own beliefs and assumptions, examining where they come from, and how they contribute to maintaining systems of inequality. In the context of GAHC, this would necessitate recognition of heteronormativity and cisnormativity and consciously working to counter the accompanying assumptions, while acknowledging LGBTQ presence in health care, and increasing its visibility (Baker & Beagan, 2014). An example of where this is not evident, is a Canadian study of TGD medical students (K. Butler et al., 2019), where participants described a cisnormative medical culture that marginalizes the existence of TGD people. Cultural humility has been described as a key component for creating a welcoming clinic environment for transgender people (Deutsch, 2016),and is recognised in a

WHO publication as a key element for education on transgender health in medical schools (Hana et al., 2021).

Next, I will discuss the concept of ‘hidden curricula’ that can play an important role in the context in which medical students learn, or do not learn, about gender diversity.

2.5.2 The concept of the ‘Hidden Curriculum’

The earliest Hidden Curriculum (HC) reference is a 1965 research report titled “the hidden curriculum in the middle-class home” by Fred L. Strodtbeck, a Harvard PhD. (Hafferty & Martimianakis, 2018). Strodtbeck studied the social advantages differentially acquired by children from middle class homes versus children from low to very low-income households. Hafferty comments that Strodtbeck was concerned about ‘social capital’ – although this term had not yet made its way into the sociological lexicon at the time (Hafferty & Martimianakis, 2018). “Hidden curriculum” in the educational sphere was first used by Phillip Jackson to distinguish it from “official curriculum” (Jackson, 1968, p. 33).Hafferty & Franks, drawing on the sociological and educational literature, brought the concept of the hidden curriculum to Medical Education in their 1994 article, titled “The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education” (Hafferty & Franks, 1994).

Hafferty defined the term “hidden curriculum” (HC) with respect to medical education specifically as the “set of influences that function at the level of organizational structure and culture” (Hafferty, 1998, p. 404). This he contrasts with the formal curriculum and the “informal curriculum”, described as “the unscripted and highly interpersonal form of teaching and learning that takes place between faculty and students” (Hafferty, 1998). This results in a distinction between what students are taught and what they learn.

The subsequent widespread focus on the HC in medical education research and publication was critiqued by Anna MacLeod as it had the potential to “allow us to disavow ourselves of responsibility” for action (Macleod, 2014, p. 540). She argued that problematic practices in medical education are actually not hidden and should be addressed (Macleod, 2014).

Martimianakis et al. (2015) provide a further critical stance based on their charting the educational effects of linking the construct of HC to ideas of humanism. They identified a preoccupation in HC literature with negative role modelling by physician teachers. Certain types of interventions were prioritised, e.g., reforms targeting problematic behaviours of medical students and teachers – but with very little consideration for the role that institutions and broader socio-political relations could play in giving rise to such problematic behaviours. This view of the HC suggests that the HC is something that is "done to" students. Martimianakis et al. comment that:

> It is therefore not surprising that a majority of reform efforts are also aimed at trying to "do something to" medical students (i.e., enhancing humanistic attributes and characteristics through formal instruction), rather than addressing the overarching institutional culture (Martimianakis et al., 2015, p. S10).

In 2018, Lawrence et al. published a scoping review on the Hidden Curricula of Medical Education (Lawrence et al., 2018). In response to Anna MacLeod's question, "Is it time to re-consider the concept?", they argue that learning environments are composed of a multiplicity of hidden curricula, not blanketed by a singular HC, and describe four conceptual boundaries: (1) institutional-organizational, (2) interpersonal-social, (3) contextual-cultural, and/or (4) motivational-psychological. Hafferty & Martimianakis (2018) in response to this article, acknowledge that the phenomenon of the HC has numerous and dynamic manifestations. In contrast to Lawrence et al. (2018) who want scholars to specify conceptual boundaries, they welcome different perspectives on HC.

> Our overall point is one of contextual sensitization and inclusiveness. Although one can learn a great deal about the HC by limiting oneself to works that explicitly identify or expressly label the HC, one also can learn too little. A wealth of work within the social sciences, education, and nursing that is HC-like and HC-informing contributes to our understandings of the dance between formal and other-than-formal dimensions of learning specifically, and social life more generally (Hafferty & Martimianakis, 2018, p. 528).

The concept of the HC is widely used, and is used to describe the marginalisation of different populations based on race, gender, disability etc. The HC can include the implicit, often highly gendered, and discriminatory values that students are taught in

education settings (Giles & Hill, 2015). An article describing the challenges of including gender and sexuality in curricula at a South African health science faculty suggest that the influence of the HC is significant, in that the institutional culture was not supportive of including LGBT health topics (Müller & Crawford-Browne, 2013). In 2020, a study was published titled: "Exploring the Hidden Curriculum's Impact on Medical Students: Professionalism, Identity Formation, and the Need for Transparency" (Brown et al., 2020). They report that "senior students identified the hidden curriculum as having as least as large an impact as the formal curriculum." (Brown et al., 2020, p. 1114). In this study, role modelling was seen as a key element of the HC. A recent Canadian study exploring the HC phenomenon, found that negative expressions of the HC were more likely to be experienced by women and respondents who identified as non-binary or preferring not to gender identify, compared to male respondents (Schultz et al., 2023).

Hafferty & Martimianakis (2018) comment that both 'hidden' and 'curriculum' are problematic words. The word 'hidden' "biases us toward the more implicit, unintended, and tacit sides of learning – even as we know that much of social learning takes place within an interstitial space between the formal and a range of other-than-formal domains of learning" (Hafferty & Martimianakis, 2018, p. 530). They caution that the word 'curriculum' should not restrict our thinking to the social institution of education, as learning extends beyond the walls of teaching institutions (Hafferty & Martimianakis, 2018, p. 530).

In conclusion for this discussion on the HC, it has to be recognised that the HC construct has been problematised and has undergone a degree of conceptual mutation in Health Professions Education (HPE) literature (Hafferty & Martimianakis, 2018). Whatever terms are used, it is important to look at the dance between formal and other-than-formal dimensions of learning. I will continue to use the term HC in this thesis, as it is still frequently used in the current medical education literature (Schrewe & Martimianakis, 2022; Schultz et al., 2023). It is a relevant concept for this study, as some of the learning about GAHC and impact on the PIF of participants have been outside the formal curriculum.

The limited knowledge that we have from South Africa suggests that current medical curricula in South Africa do not create a conducive environment for the development of a gender-affirming practitioner (Müller, 2013; Spencer et al., 2017). Therefore, we need to think about curriculum change, as one aspect of creating a conducive environment, which will be discussed in the next section.

2.5.3 Curriculum change

The redesign of health professional education has been called for internationally. An example is the Lancet Commission overview entitled "Health professionals for a new century: transforming education to strengthen health systems in an interdependent world" (Frenk et al., 2010). The Commission's vision is that:

> all health professionals in all countries should be educated to mobilise knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams (Frenk et al., 2010, p. 1924).

DasGupta and colleagues argue that incorporating social justice into the education of medical professionalism is critical and ask, "how do we as medical educators construct a pedagogy for social justice that is far reaching, consistent and central to our educational endeavours?" (DasGupta et al., 2006, p. 247). They suggest teaching with a Freirian vision to openly address power discrepancies between teacher and learner, while valuing and respecting the input of both, with educators "modelling non-hierarchical and respectful relationships that trainees can then translate into their clinical care" (DasGupta et al., 2006, p. 251).

The South African report titled "Reconceptualising Health Professions Education in South Africa" (Academy of Science of South Africa, 2018) includes social accountability and addressing the country's burden of disease as goals for HPE (Academy of Science of South Africa, 2018). This emphasis on social accountability and responsiveness to population needs fits with the focus of this study, to explore how the needs of TGD people can be included into a medical curriculum. Curriculum change is needed in order to train health professionals to be more socially accountable and able to work in teams to strengthen health systems that are responsive to the need of communities (Academy of Science of South Africa, 2018).

The Academy of Science report (Academy of Science of South Africa, 2018) refers to the theory of transformative learning (TL), which was first described by Mezirow (Mezirow, 1997). Frenk et al. (2010) describe moving from informative to formative to transformative learning:

> Informative learning is about acquiring knowledge and skills; its purpose is to produce experts. Formative learning is about socialising students around values; its purpose is to produce professionals. Transformative learning is about developing leadership attributes; its purpose is to produce enlightened change agents (Frenk et al., 2010, p. 1924).

TL is described as learning that can change the way we see the world, through reflection on an experience that challenges preconceived understandings (Van Schalkwyk et al., 2019). For TL to be possible, opportunities are needed where students can question existing beliefs and prejudices, and students need to have the capacity to change in response to unfamiliar environments (Van Schalkwyk et al., 2019). A transformed view of the world can give students the opportunity to examine social injustices that lead to health inequities (Van Schalkwyk et al., 2019).

Green-Thompson and colleagues regard curriculum as an important channel for producing socially accountable graduates (Green-Thompson et al., 2018). Pentecost et al. (2018) argue that it is critical to cultivate a social ethic as part of a process of decolonising health science curricula (Pentecost et al., 2018). This includes student awareness of social context and social justice in the practice of medicine, and students' understanding that they are actors with values – informed by historical and socio-political factors – that shape clinical interactions (Pentecost et al., 2018). From a medical ethics perspective, Ssebunnya (2013) advocates for respect for human dignity as a central conceptual focus of health sciences training in Africa (Ssebunnya, 2013). This is a key component of social accountability. Wood et al (2021) argue that while the idea of social accountability articulates a rationale and aspirations, a learning health system is needed to operationalise it (Wood et al., 2021). Both social accountability and a learning health system promote partnerships between communities, the health system and health professions education in order to co-design interventions relevant to the local context (Wood et al., 2021).

Curriculum change takes place in a context. The 2018 UCT Curriculum Change Framework (UCT Curriculum Change Working Group, 2018), describes the context of “Fees must Fall” and how to adopt a decolonial lens in curriculum change. “Decoloniality of knowledge troubles these patriarchal and heteronormative, racist and ableist assumptions about knowledge and the legitimate thinker, and challenges Euro-American authority on what counts as knowledge” (UCT Curriculum Change Working Group, 2018, p. 21).

This Curriculum Change Framework describes a theory of change with different phases. In the contestation phase, the curriculum “is scrutinized for its role and power to marginalize the voiceless and the least powerful” (UCT Curriculum Change Working Group, 2018, p. 25). Contestation can be generative, with increasing recognition of the knowledge of people located on the margins of society and who have suffered oppression, including members of the LGBQTIA+ community, disabled people, the economically and politically disenfranchised, etc.

In the re-positioning phase, “agents actively reposition themselves, their ideological standpoints and knowledge from notions of ‘disadvantage’ or ‘equity’ towards genuinely embedding marginalised knowledge at the core of the curriculum” (UCT Curriculum Change Working Group, 2018, p. 27). The reconstruction phase includes revisiting own history and cultural identities, with ‘un-learning’ of particular ways of reading and interpreting this knowledge, followed by reconstitution and reflection phases. This links with GAHC, where health professionals may need to ‘un-learn’ specific things, e.g., a cis-heteronormative approach and a paternalistic approach to decision making.

In the recommendations of this report, it is stated: “A decolonial approach to curriculum seeks to be necessarily inclusive. It introduces the question, who is the curriculum for? And further seeks to engage all stakeholders in the work of curriculum change and knowledge making.” (UCT Curriculum Change Working Group, 2018, p. 57). Regarding decolonial pedagogy, the report criticises traditional teacher-student relationships that re-enforce hierarchies of power and privilege. A decolonial approach to pedagogy is encouraged, so that pedagogic relationships

between teachers and students can be inclusive, socially just, and constructive. Eichbaum et al. (2021) call for decolonising medical education, to confront imbalanced power dynamics (Eichbaum et al., 2021). Nemutandani, Hendricks and Mulaudzi (2018) argue that a decolonising approach to healthcare can be powerful in shifting mindsets and attitudes (Nemutandani et al., 2018). This is important as the influence of medical colonial legacies is still present, with scientific enquiry often valued more than empathy (Lokugamage et al., 2020).

The Curriculum Change Framework emphasises the critical role that students must play in informing meaningful curriculum change (UCT Curriculum Change Working Group, 2018). Other authors too have emphasised the importance of student voice in a decolonising approach to curriculum reform (Adam et al., 2014; Behari-Leak & Mokou, 2019; Le Grange, 2016).

Sharma (2018) argues that meaningful patient involvement in curricula can be considered an act of decolonisation (Sharma, 2018). She cautions about the way in which patient voices are included. It could perpetuate colonial ways of knowing and representing the 'other' if there is no recognition by medical providers of their privilege and how practitioners have marginalised those voices to begin with (Sharma, 2018).

Luckett and Shay (2020) write about curriculum transformation as a way to challenge and dismantle structural injustices.

> A transformative approach would involve dismantling the power relations, social hierarchies and cultural hegemonies that currently underpin the canons, the assumed norms and values of inherited curricula and setting up processes to reimagine more inclusive ways of participating in curriculum and pedagogic practices (Luckett & Shay, 2017, p. 3).

They suggest that "a transformative approach to curriculum reframing should consciously address questions of difference and power, taking into account the ways in which lecturer and student subjectivities are implicated in knowledge production and pedagogic practice" (Luckett & Shay, 2017, p. 11).

How lecturer subjectivities are implicated in knowledge production is a difficult aspect to address. Paton et al (2020) use Audre Lorde's concept of the "master's house" to critique health professions education (Paton et al., 2020). Audre Lorde used the words "The Master's Tools Will Never Dismantle the Master's House" in a speech in 1979 to criticise how power was used in feminism, and this was subsequently published (Lorde, 2007, p. 111). Lorde gave the speech at a conference on feminist theory, where only two speakers were black women, and argued that white feminists used the tools of a racist patriarchy in how they viewed difference between women. Paton et al. (2020) argue that "The House of Health Professions Education" reproduces domination and privilege, with status and education regarded as individual achievement rather than "a means for improving circumstances within society" (Paton et al., 2020, p. 1110) . This places more value on individual professional responsibility in practice than social responsibility.

> In order to dismantle the hegemonic practices that support the Master's House, we suggest the use of a range of pedagogies, such as those taken from Freire's Pedagogy of the Oppressed (2000) or hooks' *Teaching to Transgress* (2014), which employ critical reflection and reflexivity to better understand how one's own identity and practices contribute to the solidification and exportation of normative discourses in HPE. (Paton et al., 2020, p. 1119)

Leibowitz (2017) argues that "The notion of a 'decolonised curriculum' is all embracing in that it cannot happen in a piecemeal fashion, where one or two individuals tinker with their module frameworks – rather, it requires all role players to become involved" (Leibowitz, 2017, p. 94).

Medical educators need to be critically conscious of power dynamics in the learning environment (Sandars, 2017). Power operates both at a structural (macro) and interactional (micro) level and is manifested in medical education through hierarchies (Vanstone & Grierson, 2022). Aspects of power that will be explored in this study include power at institutional level (Zaidi et al., 2017), power relationships in the clinical encounter (Kuper et al., 2017; Tervalon & Murray-García, 1998; Thomas et al., 2020) as well as hierarchical teacher-student relationships (Green-Thompson et al., 2018; UCT Curriculum Change Working Group, 2018).

For curriculum change, critical reflection by health professions educators will be required, to recognise power relations and consider ways to effect systemic change. I will discuss the implications of this study for curriculum change in Chapter 8. The next section will explore how medical students have reported their experiences of the medical school environment.

2.6 Student experiences of the medical school environment

In a South African study, Mokhachane et al. (2023) found that participants experienced the institutions where they trained as an alienating space, with oppressive training environments, and experiences of discrimination based on both race and gender (Mokhachane et al., 2023).

In a literature review of negative aspects of the medical school learning environment, Damiano et al (2019) identified ten main negative areas that included minorities discrimination; sexual discrimination; violence; bullying; racism and homophobia (Damiano et al., 2019). A 2019 Report of the Faculty of Health Sciences Mental Health Working Group at UCT, titled "Report on the Faculty-based engagements with stakeholders: understanding 'uMgowo'", described the university culture as dehumanising, with students reporting their own familial and community ways of being clashing ways of being within the FHS (Galvaan et al., 2019).

In a study of medical student reflection on social accountability, Green-Thompson, McInerney & Woollard (2018) found that 'knowing one's place' becomes a negative aspect of the hierarchy in terms of advocacy on behalf of patients and in the observation of inappropriate conduct (Green-Thompson et al., 2018). A study at Harvard medical school had similar findings, where students described abuse of power in medical training (Gaufberg et al., 2010). Students described feeling disempowered and disrespected, with the medical hierarchy pressuring them to know their place (Gaufberg et al., 2010). Hierarchical relationships were also identified in a recent study of medical students' experiences of mistreatment by clinicians and academics at a South African university (Crombie et al., 2023). This study describes that hierarchical relationships can lead to trainees feeling that they cannot speak out against abuse out of fear of punishment or discrimination, with

78.2% of the medical students that reported having experienced some form of mistreatment by senior doctors or other hospital staff (Crombie et al., 2023). Gender discrimination was reported by 29.7% and racial discrimination by 33.7% of the participants (Crombie et al., 2023).

It is important to point out that although hierarchy certainly has negative aspects as described above, it is not all negative (Vanstone & Grierson, 2022). Cruess et al. (2018) state that:

> it is not possible to envisage any enterprise as complex as the medical profession without boundaries, hierarchies, or power structures. It is the nature and impact of these essential elements that sometimes deserve criticism and attention, not their existence (Cruess et al., 2018, p. 187).

Hierarchies play a role in establishing a social order and expected rules for conduct. Medical students have described understanding and adhering to these rules as a way to demonstrate professionalism as well as to develop successful relationships with their supervisors (Vanstone & Grierson, 2019).

A study of the HC related to gender at a medical school in Taiwan (Cheng & Yang, 2015), described gendered stereotypes of physiological knowledge; biased treatment of women; sexual harassment and a hostile environment, as well as ridiculing of LGBT people. Pervasive heteronormativity was also described in an ethnographic study in the USA (Murphy, 2014). A Canadian study of TGD medical students (K. Butler et al., 2019), reported that participants described a cisnormative medical culture that marginalizes the existence of TGD people.

Another aspect of student experience is that scientific knowledge is often viewed as more important than the humanistic aspects of medicine. Martimianakis et al. (2015) describe that students receive implicit messages that humanism is secondary to clinical scientific knowledge (Martimianakis et al., 2015). This occurs in a context where the “prevailing metaphors of medical education continue to be heavily mechanistic (the body is a machine), linear (find the cause, create an effect), and hierarchical (doctor as expert)” (Shapiro et al., 2009, p. 192). Jacobs et al (2020) documented this tension as well, between the relative importance of clinical

competence and critical consciousness (Jacobs et al., 2020). Inclusion of the humanities in medical curricula in South Africa have been discussed by Pentecost et al. (2018), whereas Eichbaum et al. (2019) discuss this for an African context, and Carr et al (2022) published an international framework (Carr et al., 2022; Eichbaum et al., 2019; Pentecost et al., 2018). Pentecost et al. argue from a decolonising stance, for a conceptual framework that includes both the sciences and humanities, that should be integrated throughout the curriculum. They propose four competencies:

> (1) the integration of previously marginalised sources of knowledge (challenging knowledge hierarchies and decolonising curricula); (2) the integration of an appropriate intellectual self-image in health sciences education (challenging the image of the health professional); (3) an integrated understanding of history and social context, centring issues of inclusion, access and social justice (cultivating a social ethic) and (4) an integrated focus on care and relatedness as an essential aspect of clinical work (embedding relatedness in practice) (Pentecost et al., 2018).

Eichbaum et al. argue that contextual congruent humanities teaching has a vital role in low resource settings, as it can help develop critical consciousness (Eichbaum et al., 2019). This is aspirational work, to include more humanities teaching in curricula, and Pillay & Kathard (2015) caution that resistance can be expected to a decolonising approach to curricula (Pillay & Kathard, 2015).

2.7 Patient experiences and perspectives of GAHC

Although the published article included in the first part of this chapter discusses the question "Do TGD people experience stigma and discrimination in health care settings?" this focuses on negative experiences. There is specific literature on the experiences of TGD patients as well as TGD health professionals that deserve to be mentioned in this literature review, because of its relevance to the later analysis.

Positive experiences of GAHC are much less described in the literature compared to negative experiences. A mixed methods online study in the USA (Baldwin et al., 2018), found that descriptions of positive interactions were characterized by use of language that demonstrated respect for diverse gender identities. A qualitative study

in Australia had similar findings, with positive attributes of services identified as respectful communication styles, welcoming spaces, as well as care and openness (Haire et al., 2021). A Canadian study about implementation of primary care services for transgender individuals, identifies implementing a safe space as a key responsibility of practitioners (Ziegler et al., 2019).

A positive experience of accessing GAHC can even lead to what has been referred to as gender euphoria. Gender euphoria is a relatively recent term that originated in gender minority communities and is not common in academic literature (Beischel et al., 2022), although it was already used in 2010 by Benestad, a trans activist and sexologist (Benestad, 2010). Ashley and Ells (2018) define gender euphoria as “a distinct enjoyment or satisfaction caused by the correspondence between the person’s gender identity and gendered features associated with a gender other than the one assigned at birth” (Ashley & Ells, 2018, p. 24). A recent qualitative study found that it was understood as “a joyful feeling of rightness in one’s gender/sex”, (Beischel et al., 2021, p. 281). The authors found that “central to these positive emotions are a constellation of feelings related to authenticity, rightness, or being “at home” (Beischel et al., 2021, p. 286) .

2.8 Experiences of TGD health professionals providing GAHC

There is not much literature describing the experiences of TGD health professionals providing GAHC. Studies reporting LGBTQ+ professionals experiences at work have very few TGD participants (Beagan et al., 2023; Bizzeth & Beagan, 2023; Eliason et al., 2011). An online survey of transgender and gender non-binary medical students and physicians found that in many cases individuals hid their identity due to fear of discrimination, substantiated by witnessing high levels of anti-TGD stigma and discrimination (Dimant et al., 2019). This study did not report on experiences of providing care (Dimant et al., 2019). A recent qualitative study of the experiences of transgender and gender expansive physicians reported emotional distress because of transphobia and found that structural and institutional factors reinforced the binary paradigm and exacerbated the emotional distress (Westafer et al., 2022).

2.9 Summary

This literature review described the health disparities experienced by TGD people, as well as experiences of discrimination in health care settings. I discussed the role of health professionals in pathologisation of TGD identities, and the responsibility of health professions educators towards curriculum change. Curriculum in the context of medical education was discussed, with consideration of the HC. The HPE literature calls for curriculum change, to give more emphasis to producing socially accountable graduates. I discussed curriculum change in the context of decoloniality, with consideration of issues of power in HPE. Medical student experiences of the medical school environment are often negative, with hierarchical relationships that can lead to students feeling that they cannot speak out. Experiences of science being valued more than humanities have been discussed with recommendations in the literature to include humanities teaching as it can help develop critical consciousness in medical students. In the final part of the literature review, I looked at patient experiences of GAHC and the limited literature on the experiences of TGD health professionals providing GAHC. In the next chapter, the conceptual framework of PIF will be discussed.

Chapter 3 Conceptual Framework

3.1 Introduction

When I conceptualised this study over a time period, with many conversations with my supervisors and others, it became clear that I wanted to explore the process of how a medical student becomes a gender-affirming practitioner. I was curious about the pedagogical process of becoming. Although the field of health professions education is so broad, it slowly crystalised that PIF was a suitable conceptual lens to focus on this process of becoming. This chapter will discuss PIF from both individualist and social-contextual perspectives, factors influencing PIF, diversity in PIF as well as assessment of PIF.

3.2 Professional identity formation in medical education

Professional identity formation (PIF) has been defined as:

> the transformative journey through which one integrates the knowledge, skills, values, and behaviours of a competent, humanistic physician with one's own unique identity and core values. This continuous process fosters personal and professional growth through mentorship, self-reflection, and experiences that affirm the best practices, traditions, and ethics of the medical profession (Holden et al., 2015, p. 762).

Professionalism involves displaying the behaviour of a professional, in contrast professional identity is how an individual conceives of themselves as a doctor (Wilson et al., 2013). Professionalism and PIF have been described as interwoven processes: "as the internalization process of PIF occurs, outward professional behaviours are displayed, and as one chooses to behave as a professional, their sense of identity blossoms" (Moseley et al., 2021, p. 13). PIF can be understood as a series of processes with the three overlapping domains: professionalism; psychosocial identity development; and formation (Holden et al., 2012). It is a fluid process, that is unique to each individual and not linear (Moseley et al., 2021). PIF can include active construction, deconstruction, and reinterpretation during medical

training and even after graduation (Wald et al., 2015). For some, the adoption of a different worldview and different values may form part of PIF (Monrouxe, 2010).

The process of identity formation has been described as happening:

> simultaneously at two levels: (1) at the level of the individual, which involves the psychological development of the person and (2) at the collective level, which involves the socialization of the person into appropriate roles and forms of participation in the community's work (Jarvis-Selinger et al., 2012, p. 1186).

Identity is a complex concept that has been researched and theorised by diverse fields of study, including psychology, sociology, and philosophy (Sawatsky et al., 2020; Sawatsky & Monrouxe, 2023).

In a critical review of PIF in medical education, three theoretical perspectives were identified: individualist, social-contextual and a combination of the two (Mount et al., 2022). I will look at the individualist perspective first, followed by the social-contextual perspective.

3.2.1 Individualist perspective

Individualist theories look at PIF based on developmental stages, e.g., Kegan's stages of adult development (Kalet et al., 2017; Kegan, 1982; Lewin et al., 2019). The stages are as follows: Stage 1 Impulsive mind (2-6 years old); Stage 2 Imperial mind (6 years old through adolescence); Stage 3 Socialised mind; Stage 4 Self-authoring mind; Stage 5 Self-transforming mind (Kegan, 1982). The relevance in medical education has been criticized because the application of Kegan's stages can be very context-dependent, even within a single individual (Sawatsky et al., 2020), with students in the same group being at different stages, and no evidence that reaching a particular stage predicts future behaviour (Lewin et al., 2019).

The Ring Theory of Personhood (RToP) (Radha Krishna & Alsuwaigh, 2015) has been used as a lens to study PIF (Koh et al., 2023; Sarraf-Yazdi et al., 2021; Toh et al., 2022). This theory was developed in Singapore as a culturally appropriate model for conceptualising personhood in palliative care, from a Confucian rather than a Western perspective (Radha Krishna & Alsuwaigh, 2015). RToP can be used as a

tool to map changing concepts of personhood and evolving notions of identity (Toh et al., 2022). The four domains of personhood are described as interrelated rings: the innate, individual, relational, and societal rings (Figure 1).

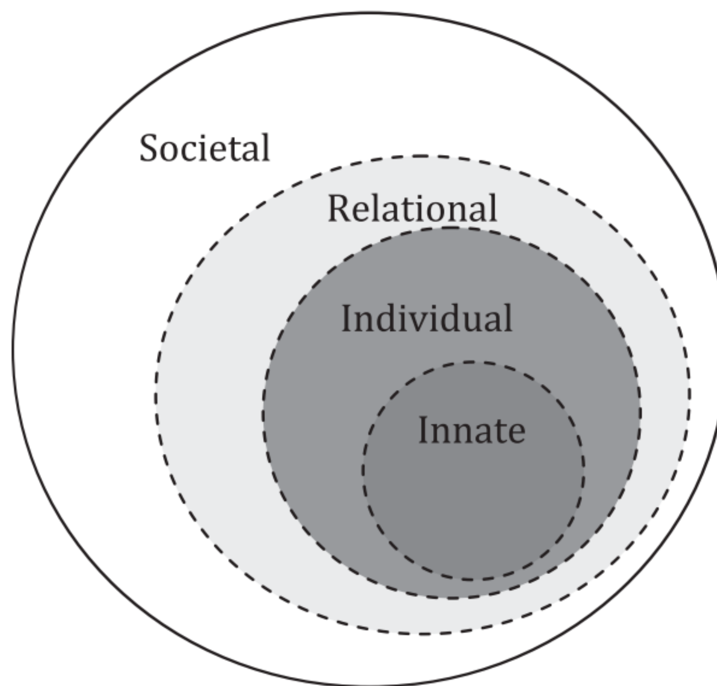


Figure 1: The Ring Theory of Personhood. Source: Radha Krishna & Alsuwaigh (2015).

The innate ring is derived from currently held spiritual, religious, moral and ethical values, beliefs and principles (Lim et al., 2023). These elements are changeable as individuals grow up and may choose to renounce certain elements (Radha Krishna & Alsuwaigh, 2015). The individual ring includes the thoughts, biases, narratives, personality, decision-making processes, and other facets of conscious functioning (Lim et al., 2023). The relational ring consists of close personal relationships and may include family and close friends. These bonds are determined by the person and may change over time (Radha Krishna & Alsuwaigh, 2015). The societal ring has two elements. The first element refers to less significant relationships, with individuals who are not given a position in the relational ring, such as acquaintances and colleagues. The second element of the societal ring encompasses societal, religious, professional, and legal expectations that guide, and govern conduct within society (Radha Krishna & Alsuwaigh, 2015). A study of the impact of death and

dying on the personhood of medical students found that conflict can arise between the different rings of personhood (Ho et al., 2020).

Medical students enter training with existing identities. These identities are the foundation on which professional identities are constructed, and certain aspects will still be present in the practitioner of the future (Cruess et al., 2014). Mokhachane et al's (2023a) South African study of PIF of medical students found that the foundation of a professional identity of a caring doctor was already present in their participants before entering medical school, with the values of ubuntu inculcated during childhood (Mokhachane et al., 2023b). They offer the metaphor of a calabash to think about PIF in an African context:

> The calabash transforms from a vegetable with a soft centre into a tool with a hardened exterior, facilitating its utility in domestic life. This transformation is reminiscent of professional identity development and formation. Symbolizing transition, the calabash is an essential part of African communion, holding water on some occasions and traditional beer on others (Mokhachane et al., 2023b).

They refer to RToP, saying that it echoes the saying in ubuntu philosophy that 'I am because you are', that emphasises the sociohistorical background that each person brings into the PIF process (Mokhachane et al., 2023). This social aspect of PIF will be explored next.

3.2.2 Social-contextual perspective

Social-contextual approaches view a person's identity development as taking place in a social context, and that identities are shaped through social interactions, relationships, and contextual influences (Mount et al., 2022). The communities of practice framework, introduced by Lave and Wenger in 1991, characterises PIF as a socialisation process (Lave & Wenger, 1991). Learning involves social interaction that takes place in a community of practice, and over time, learners move from legitimate peripheral participation to full participation (Lave & Wenger, 1991). The learner's early membership is regarded as legitimate because the community accepts them as a novice member (Cruess et al., 2018). The move involves the gradual acquisition of the required knowledge, skills, and discourse, as well as acquiring the identity of a member of their specific community (Lave & Wenger,

1991). Lave & Wenger (1991) point out that legitimate peripheral participation is a complex notion that involves relations of power in social structures. It can be an empowering position, as one moves toward more intensive participation, or a disempowering position if one is kept from participating more fully. Volpe et al. (2019) reported that students identified the culture of the profession as influencing their PIF, including hierarchy and power (Volpe et al., 2019).

Orsmond et al. (2022), drawing on the concept of Lave and Wenger's 'community of practice', comment that PIF is not something that happens to a student; rather it is an active process that can only happen with participation in a community of practice (Orsmond et al., 2022).

Health care professionals work together in shifting and dynamic settings. Professional identities are shaped by collaboratively negotiating meaning within these communities of practice (Helmich et al., 2017). The global community of medicine consists of several different communities, that of clinical care, educational practice, research, etc. (Cruess et al., 2019). Thus, in addition to multiple personal identities, a doctor can have different professional identities expressed in different contexts (Cruess et al., 2019).

Mount et al. comment that individualist and social-contextual approaches to PIF are rooted in different theoretical foundations, and give rise to distinctly different PIF interventions, focusing either on the individual student or the social context (Mount et al., 2022). They found that some researchers adopted theoretical perspectives wherein identity formation is conceptualized as an active process with both individualist and social-contextual influences. This is the approach I will take in this study, considering both the individualist and social-contextual aspects.

3.2.3 Factors influencing PIF

There are multiple factors that influence the process of socialisation in shaping a professional identity. This includes role models and mentors as well as clinical and non-clinical experiences (Cruess et al., 2015). Reflection by students on their experiences is a critical part of this process (Wald, 2015b). Other factors that play an important role include formal teaching, the learning environment, the healthcare

system, and how they are treated by patients, fellow students, and other health care professionals (Cruess et al., 2015). Clinical experiences can play a significant role, that includes learning from patients (Bleakley & Bligh, 2008).

Figure 2 is a schematic representation of PIF, by Cruess et al. (2015); and Figure 3 shows multiple factors involved in PIF, according to Cruess, et al. (2015).

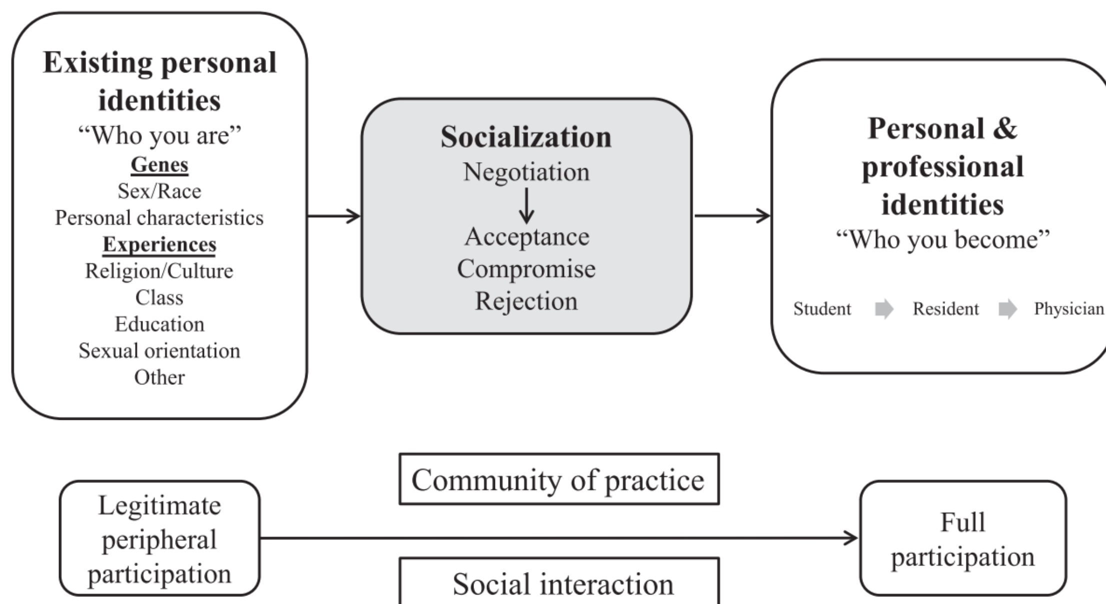


Figure 2: A schematic representation of PIF, indicating that individuals enter the process of socialization with existing identities and emerge with both personal and professional identities. Source: Cruess et al. (2015)

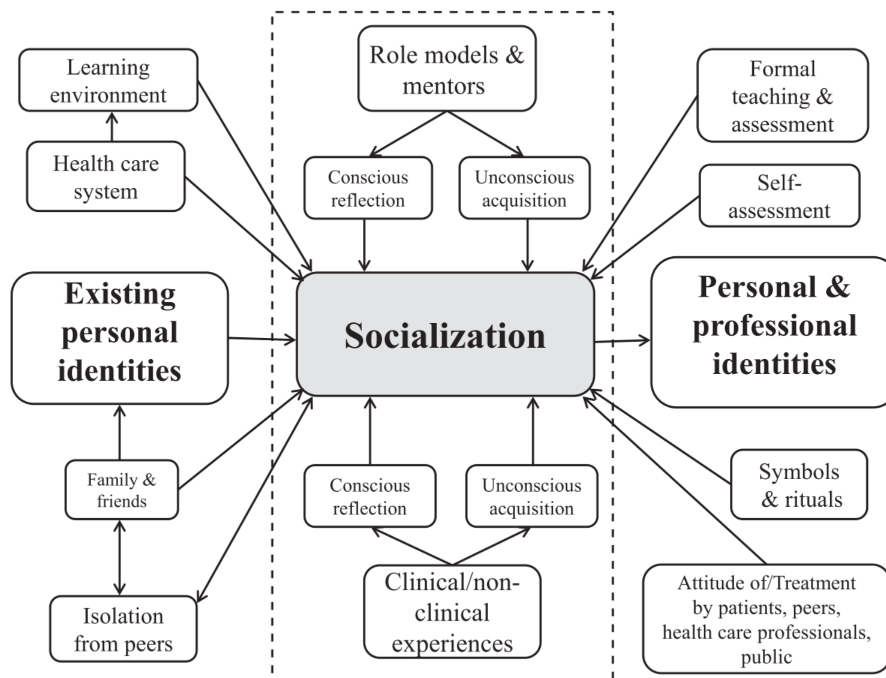


Figure 3: A schematic representation of the multiple factors involved in the process of socialisation in medicine. Source: Cruess et al. (2015)

Sarraf-Yadzi et al. (2021) offer a different perspective, viewing the factors influencing PIF through the lens of the RToP (Radha Krishna & Alsuwaigh, 2015) as individual, relational and societal (Sarraf-Yazdi et al., 2021). In their scoping review of PIF, they identified intrinsic enablers, extrinsic enablers, and barriers to PIF (Sarraf-Yazdi et al., 2021). In addition, they identified strategies adopted by medical schools to support PIF that have been described in the literature (Sarraf-Yazdi et al., 2021) such as formally incorporating humanities, enabling deliberate and guided reflection strategies, and cultivating positive role models.

Both Cruess et al. (2015) and Sarraf-Yadzi et al. (2021) emphasised reflection and role models as critical factors. I will discuss them in more depth.

Sandars (2009) defined reflection in medical education as:

> a metacognitive process that occurs before, during and after situations with the purpose of developing greater understanding of both the self and the situation so that future encounters with the situation are informed from previous encounters (Sandars, 2009, p. 685).

Wald (2015b) expanded on this earlier definition by Sandars, to specifically focus on reflection in PIF:

> Reflection is a metacognitive process including connecting with feelings that occurs before, during, and after situations with the purpose of developing greater awareness and understanding of self, other, and situation, so that future encounters with the situation including ways of being, relating, and doing are informed from previous encounters (Wald, 2015b, p. 697).

This emphasises how reflection can impact on ways of being.

Reflection has been described as a mediator between experience and identity, as it helps to make meaning from one's experiences, to identify own learning needs and integrate new knowledge (Moseley et al., 2021). A Canadian qualitative study found that reflective narratives can be an important tool for PIF, with reflection in small groups enabling exploration of new insights and integration of concepts (Wong & Trollope-Kumar, 2014). Reflective practice can assist medical students to consciously recognise the active role that they have in the formation of their own identity (Orsmond et al., 2022). Holmes et al. (2014) suggest that through reflection, students can become aware of the influence of the hidden curriculum and make intentional choices about their own PIF (Holmes et al., 2014).

The concepts of reflection and critical consciousness are closely related in the medical education literature. Critical consciousness as an intellectual construct can be useful in medical education, to foster a deep, reflexive awareness of professional power and patient-centered practices (Manca et al., 2020). Clinicians and students need to critically reflect on their own situatedness within structures (Thomas et al., 2020). Bleakley (2017) argues that if we can raise students' critical consciousness, it will enable reflection on topics such as inequality and inequity (Bleakley, 2017).

Critiques of the ways in which reflection have been practiced in medical education are emerging. Naidu and Kumagai (2016) contrast the Western emphasis of individual reflection with collaborative reflective practice that focuses on relationship building, tradition, and ritual in non-Western contexts (Naidu & Kumagai, 2016). De la Croix and Veen (2018) argue that an emphasis on assessment of reflection with

requirements for “good reflection” can lead to “reflective zombies” who write what is socially desirable rather than what they really think (de la Croix & Veen, 2018). This was also identified in a recent systematic scoping review of reflective writing (Lim et al., 2023). Lim et al. reported shortcomings of reflective writing, such as student anxiety in sharing private thoughts, that could lead to censorship of thoughts and reflections when shared with others (Lim et al., 2023). Holmes et al (2018) found that students found it easier to reflect on unprofessional behaviour of others rather than their own (Holmes et al., 2018). Lim et al. (2023) pointed out that reflective writing can be compromised when faculty are not well trained and recommend faculty development in order to create an environment where medical students are comfortable sharing their reflections and receive feedback (Lim et al., 2023). Faculty members who teach medical students can be seen as role models, which is what I will discuss next.

Bandura’s social cognitive theory provides a theoretical basis for the influence of role models, by indicating that people learn by observing what is modelled and then reproducing it (Bandura, 1986). A Brazilian qualitative study of the HC and PIF found that students felt vulnerable when exposed to negative role models, which might lead to incorporation of undesired attitudes and behaviours (Silveira et al., 2019). An Indonesian study of PIF reported that medical students experienced a discrepancy between what is taught and what is observed in daily practice in terms of professional behaviour (Findyartini et al., 2022). They recognised the value of good role models in their professional development, but also reported that negative role modelling practices inhibit their PIF (Findyartini et al., 2022).

Armyanti et al (2020) studied negative role modelling by medical teachers, and state that though this is inevitable, medical students can learn from the experiences and obtain a positive impact through self-reflection (Armyanti et al., 2020). Sternszus and Cruess (2016) concur that negative role models can have a positive effect by teaching students how not to behave (Sternszus & Cruess, 2016). Passi and Johnson (2016) found that when medical students observe a role model, they make a judgment based on whether the behaviour was perceived as positive or negative (Passi & Johnson, 2016). They report that “the medical students highlighted how the negative modelling had a positive effect because they made a judgement on how not

to behave” (Passi & Johnson, 2016, p. 704). Koh et al. (2023) used the RToP (Radha Krishna & Alsuwaigh, 2015) to review role modelling, and describe a student’s internal decision-making process to detect a learning moment, determine if it is a positive or negative experience and what they can learn from it (Koh et al., 2023). They also emphasise the significance of contextual considerations in role modelling, that play a role in addition to individual role model and student characteristics and their relationship (Koh et al., 2023).

3.2.4 Diversity in PIF

It has been argued that professionalism as a social construct is culture sensitive (Al-Eraky et al., 2014; Helmich et al., 2017). The social contract between medicine and society implies certain expectations of patients and doctors (Green-Thompson et al., 2017), and this may differ in different cultural settings globally (Helmich et al., 2017). In South Africa, the HPCSA Core Competencies (Health Professions Council of South Africa, 2011) was adapted from the CanMEDS 2005 framework (Royal College of Physicians and Surgeons of Canada, 2005). It is a contextualised version, with the medical expert role replaced by healthcare professional to broaden it beyond medicine (Academy of Science of South Africa, 2018).

Frost and Regehr (2013) describe a tension between two discourses in medical education: a discourse of standardisation and a discourse of diversity (Frost & Regehr, 2013). They argue that the aim of medical education is not to homogenise all individual identities into a standardized medical persona that is imposed on medical students, and that it is important to maintain an individual’s personal identity as well as a diversity of identities within the medical profession (Frost & Regehr, 2013). A submission-subversion dialectic is described by Haffery et al. (2016), where while on the one hand the aim is to produce a practice community that has internalised core occupational values, on the other hand a willingness to resist entrenched assumptions about the profession is required (Hafferty et al., 2016). They describe the paradox that PIF should result in professionals who “not only resist ritualistically applying routine solutions to complex problems but also seek to disrupt the very systems that gave rise to that identity to begin with” (Hafferty et al., 2016, p. 173). They argue that within a health system where there is a tension between bureaucracy and a collective sense of doctors as a disruptive work force in

the service of patients, PIF should be a process that fosters disruption over compliance and certitudes (Hafferty et al., 2016).

Criticism of PIF research in the health professions has emerged, pointing out that power relations in PIF have not been considered in sufficient depth (Cornett et al., 2022; Volpe et al., 2019). The intersectionality of history, culture, race, socioeconomic status, and gender need to be considered to build a more nuanced and contextual understanding of identity (Tsouroufli et al., 2011). Schrewe and Martiaminakis (2022) caution that medical education may be "unintentionally complicit in reinforcing a certain assumptive professional typology of "a good physician", one closely aligned with white, male, heterosexual, affluent, ableist, and Western-centric personal identities" (Schrewe & Martimianakis, 2022, p. 849). They argue that when studying PIF, deep consideration should be given to the backgrounds and contexts within which PIF plays out. Wyatt et al. (2021) looked at PIF literature though a post-colonial lens and found that current framings of PIF may be insufficient to examine the experiences of students from racial and ethnic minorities (Wyatt et al., 2021). They identified four key conceptual areas that influence PIF: "Individual versus Sociocultural Influences; the Formal versus the Hidden Curriculum; Institutional versus Societal Values; and Negotiation of Identity versus Dissonance in Identity" (Wyatt et al., 2021, p. 148). A study of PIF in African American physicians found that the culture of medicine is perceived as precarious for black professionals; unwelcoming, leading them to be constantly on alert and having to watch their back (Wyatt et al., 2021). In the South African context, although black medical students are no longer a minority group, they still report negative experiences. Mokhachane et al. (2023) found that South African medical graduates who appeared different from the norm, were judged by colleagues, with their identities muted as they were not allowed to bring "their 'African-ness' into the training spaces" (Mokhachane, et al., 2023, p. 5).

3.2.5 Assessment of PIF

Although assessment of PIF is essential, it is not straightforward as PIF is a complex, nonlinear, developmental process influenced by many different factors (Holden et al., 2015). It has been proposed that Miller's pyramid be adapted,

that above “Does,” the apex should be occupied by an added level: “Is” as depicted in Figure 4 (Cruess et al., 2016, p. 181). The attitudes, values and attributes of a professional identity is difficult to assess directly because of their subjective nature. Tay et al. propose competency based stages of professionalism assessment that includes the “Is” (identity) aspect, where tools should be specific to different stages of professionalism development or be sufficiently flexible to account for differences in the learner’s abilities and setting (Tay et al., 2020). Assessing the “Is”, which includes self-knowledge of students about themselves, should be formative to engage students to trace their own development (Cruess et al., 2016).

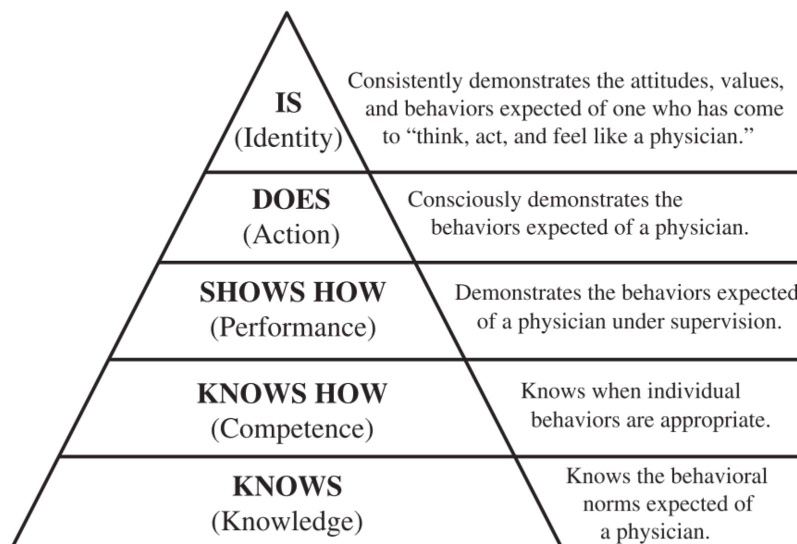


Figure 4: The amended version of Miller’s pyramid with the addition of “Is”. Source: Cruess et al. (2016)

Moseley et al. (2021) suggest that multiple formative assessments and mixed method approaches can be used to assess PIF, as the goal is to provide feedback to support identity development, rather than as a summative assessment at one point in time (Moseley et al., 2021). In a scoping review of assessment in PIF, Teo et al. (2022) grouped the tools used according to the stages of the amended Miller’s pyramid (Teo et al., 2022). They concur with Moseley et al. that assessment of PIF should be a multi-source and multidimensional process involving a variety of tools (Teo et al., 2022). Ellaway et al. (2022) differentiate between learning sessions and summative assessment. They suggest that TGD learning sessions should not be

summatively assessed in order to promote student safety. However, medical knowledge on TGD topics can be examined in summative assessments, and TGD knowledge and skills in an OSCE (Ellaway et al., 2022).

3.3 Summary

In this chapter, I have discussed PIF as the conceptual framework for this study, to look at the process of how a medical student can become a gender-affirming practitioner. PIF can be studied from individualist and social-contextual perspectives, or from both (Mount et al., 2022). I intend to use both perspectives as the process of becoming gender affirming is an individual process that happens in a social context. This relates to the narrative inquiry approach of a three-dimensional narrative inquiry space with dimensions of temporality (time), place (context) and sociality (Clandinin et al., 2017). In the next chapter, the methodology will be discussed.

CHAPTER 4 METHODOLOGY

4.1 Introduction

In this chapter I will present my paradigmatic positioning as well as the rationale for my choice of using case study combined with narrative inquiry as complementary methodological frameworks. The two phases will be described, with the data generation methods.

4.2 My paradigmatic positioning

This study is situated in a critical research paradigm. What critical approaches have in common, is the intent to understand and to disrupt notions of truth and power structures that society has taken for granted (Hodges, 2014). Critical theory aims to raise awareness of a situation, which is a crucial step before changes can be made to reduce the inequities (Sandars, 2017). Brian Hodges comments that “critical scholars in medical education study the socio-economic, gender, racial, sexual, cultural and linguistic correlates of persistent or growing inequities” (Hodges, 2014, p. 1044). As my research topic was inspired by my observation of health inequities in TGD people and the difficulties accessing GAHC, it is suitable to use a critical research paradigm. The ontological assumptions of critical theory are that there are “multiple subjective realities influenced by power relations in society. Reality is shaped by social, political, cultural, economic, ethnic, and gender values” (Brown & Dueñas, 2020, p. 548). The epistemological assumptions of critical theory are that “knowledge is also subjective but created and negotiated between individuals and within groups” (Brown & Dueñas, 2020, p.548).

A critical look at the gender system is relevant, while recognizing than an extensive discussion thereof is beyond the scope of this study. Gender is not only an identity or role, but an institutionalized system of social practices (Ridgeway & Correll, 2004). In the gender system, people have traditionally been categorized into men and women, with social relations of inequality based on the difference between these categories. Cultural beliefs about gender and social relational contexts play significant roles in the gender system (Ridgeway & Correll, 2004). This binary view of gender has been

prevalent in the Western world and is viewed as directly following from biological sex (Morgenroth & Ryan, 2021). The gender binary system supports patriarchal systems, as Mitchell states: “in order for men to be superior to women, ‘men’ and ‘women’ must be coherent, stable, and meaningful categories” (Mitchell, 2022, p. 5)

In more recent years, views of gender and sex have been changing slowly. Second-wave feminist theory argued for a distinction between sex and gender to disrupt the equation of physical characteristics with social roles (Butler, 1990). In GAHC discourses, there is an understanding of “a diverse array of gender identities and expressions” (Coleman et al., 2022, p. S6) beyond a binary view of gender.

There has, however, been stark opposition to these changing views, with opponents arguing that biological sex is binary and determines gender (Morgenroth & Ryan, 2021). Judith Butler (2024) describes an anti-gender ideology movement that opposes reproductive justice, undermines forms of protection against gender-based violence and strips TGD people of their right to live without the threat of violence (J. Butler, 2024).

Mitchell (2022) argues that TGD people have the potential to threaten existing systems of gender, specifically, the gender binary and patriarchy. Transprejudice has been framed as “gender-system maintenance”, therefore discrimination against TGD people can be understood as a reaction to transgender threats of gender systems (Mitchell, 2022).

Paulo Freire is one of the first educational thinkers who philosophised about critical pedagogy (McLaren, 1999), with his landmark publication *Pedagogy of the Oppressed* (Freire, 1970). He described critical pedagogy as a means of empowering people to effect societal change, via “critical consciousness”, which is awareness and questioning of assumptions, power, and privilege (Freire, 1970). Critical consciousness as an intellectual construct can be useful in medical education, to foster a deep, reflexive awareness of professional power and patient-centered practices (Manca et al., 2020). Critical pedagogy “offers a philosophical perspective in which critical theory is applied to understand and change the practice of education” (Sandars, 2017, p. 351). Another important voice in critical pedagogy,

Peter McLaren, states that “Freirean pedagogy is vitally important for contemporary educators to revisit, to build upon, and to reinvent in the contextual specificity of today's socio-political context with its traumatising inequalities” (McLaren, 1999, p. 54). Kincheloe (2007) said that in critical pedagogy, researchers become detectives of new theoretical insights, by searching for novel ways of understanding power and oppression and their impact on everyday life and human experience (Kincheloe, 2007). A critical pedagogy approach seemed to be the best choice for this study as the knowledge generated will inform medical education.

4.3 Study design: case study combined with narrative inquiry as complementary methodological frameworks

At the beginning of this research, I aimed to develop an in-depth understanding of the phenomenon of the PIF of a gender-affirming practitioner through a relevant curriculum. This is an interdisciplinary study, as it explores aspects of medical education as well as gender-affirming healthcare, which is interdisciplinary in nature as it involves integration of knowledge from different disciplines. I chose qualitative methods, as the primary goal of qualitative research is to explore and interpret the experiences of participants **(Tavakol & Sandars, 2014b)**. To answer the research question, which is a complex one, I had to bring together case study and narrative inquiry as complementary methodological frameworks. I will first discuss qualitative case study research, and then explain why I chose narrative inquiry as a complementary methodological framework.

Qualitative case study research is an approach in which the researcher explores a bounded system (a case) or multiple bounded systems (cases) over time (Yazan, 2015). This takes place through detailed, in-depth data generation that involves multiple sources of information, resulting in a case description and case-based themes (Baxter & Jack, 2008). The fundamental goal of case study research is to perform an in-depth analysis of an issue, within its context, in order to understand the issue from the perspective of participants (Harrison et al., 2017). In case study research, the researcher can answer “how” and “why” type questions, while considering how a phenomenon is influenced by the context within which it occurs (Baxter & Jack, 2008). I chose this as suitable methodology for this study as I have

been curious about the “how” of becoming a gender-affirming practitioner as well as the how this is influenced by context of medical education in South Africa.

The case for this study is the process of PIF of a gender-affirming practitioner in a South African context. The case is bounded in terms of participants, location, process to be explored and timeframe. The participants are health professionals, medical students, and medical educators. The location is South Africa, with the medical educators situated in different provinces, and for the medical students, medical educators, and document analysis the context is two universities in one province in South Africa. The process explored is the PIF of a gender-affirming practitioner and the timeframe is the period during which the data generation took place, 2019-2020. It is a single case with embedded units (practitioners and medical students).

Qualitative case study research uses multiple methods to generate and analyse data, which can be mutually informative and together provide a more synergistic and comprehensive view of the phenomenon (Harrison et al., 2017). In this study, I used the following methods: narrative interviews, participant reflective journals, a facilitated group engagement with medical educators, document analysis as well as field notes and a reflective research journal. The analysis of the data that was generated in two phases, as will be described in 4.4 below, contributed to the case.

In case study research, data from these multiple sources are then brought together in the analysis process.

> Each data source is one piece of the ‘puzzle’, with each piece contributing to the researcher’s understanding of the whole phenomenon. This convergence adds strength to the findings as the various strands of data are braided together to promote a greater understanding of the case (Baxter & Jack, 2008, p. 554).

To get an in-depth understanding of the case, I realised that I needed to listen to practitioners and students as they tell their own stories of becoming gender-affirming practitioners. Narrative inquiry was chosen as a suitable research methodology for getting to the deeper meaning, as I will discuss below.

In the human sciences, narrative analysis refers to a family of approaches to different kinds of texts, which have a storied form in common (Riessman, 2005). Narrative inquiry as a methodology was first used by Connelly and Clandinin (1990) to describe the personal stories of teachers. Their development of narrative inquiry as a research methodology was influenced by the philosopher John Dewey (Dewey, 1938). Dewey was a philosopher of experience and an educational theorist. He based his principles on interaction and continuity, and theorised that the terms personal, social, temporal, and situation were important when the characteristics of an experience is described (Wang & Geale, 2015). Based on Dewey's theory, Connelly and Clandinin (1990) described a three-dimensional narrative inquiry space with dimensions of temporality, place, and sociality (Clandinin et al., 2017; Connelly & Clandinin, 1990). This highlights the relational dimension of narrative inquiry, where the researcher is part of the process, inquiring into participant experiences as well as their own experiences, to enable co-construction of knowledge (Clandinin, 2006).

Narrative research has been used in medical education research of both students and staff. Helmich et al. (2012) used narrative interviews to study medical students' experiences during early clinical exposure (Helmich et al., 2012). The PIF of physicians in a faculty development programme were studied using narrative analysis (Branch & Frankel, 2016), as were the professionalism dilemmas in medical students (Rees et al., 2013). A study of PIF in medical students, using narrative analysis, described five themes: "prior experiences, role models, patient encounters, curriculum (formal and hidden) and societal expectations" (Wong & Trollope-Kumar, 2014, p. 489). In addition, narrative analysis has been utilised to study the PIF of family medicine residents in palliative care (Kilbertus et al., 2020). Clandinin et al. (2017), assert that: "Within a narrative conception of experience, identity development is a narrative phenomenon and narrative inquiry is an appropriate methodology to study medical learners' identity development" (Clandinin et al., 2017, p. 92). As I set out to study the PIF of a gender-affirming practitioner, this resonated with me, and narrative inquiry seemed ideally suited as one of the data generation methods for the case study. This choice of methodology aligns with the epistemological assumptions of a critical research paradigm, recognising that

knowledge is subjective and that it is created between individuals (Brown & Dueñas, 2020).

Data sets were generated in two phases for this study. In the first phase practitioners as well as medical students were purposively sampled for individual interviews that used a narrative inquiry approach. A narrative analysis was conducted (Kim, 2016). In phase two the narrative analysis, represented as stories, was presented to a purposive sample of medical educators to explore ways of developing a gender-affirming curriculum; their discussion was analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2019). Regulatory policy and university curriculum documents were analysed as part of phase two. Other data sources were participant reflective journals from phase one and the researcher's reflective journal. Findings from the different data sources were combined for the case study analysis. Level one analysis is the narrative analysis, generating the stories; level two analysis is the reflexive thematic analysis and level three analysis the thesis building, consolidating the case.

The analysis for phase 1 is presented in Chapter 5 (Findings for Objective 1: PIF of a gender-affirming practitioner) and Chapter 6 (Findings for objective 2: Medical curriculum) in relation to the two research objectives. The analysis for phase 2 (medical educator discussion and document analysis) is included in Chapter 6. The findings from phases 1 and 2 were combined for the case analysis in Chapter 7.

Table 1: Phases of data generation with data sources, generation methods and type of data

	Data source	Data generation methods	Type of data	Analysis
Phase 1a and 1b: interviews	Practitioners and students	Narrative interviews Participant reflective journals	Audio-recorded interviews, transcribed. Written journals.	Narrative analysis
Phase 2	Medical educators Document analysis of regulatory and curriculum documents	Facilitated group engagement Document analysis	Audio-recording, transcribed. Themes generated from documents	Reflexive thematic analysis
Field notes and reflective journal kept by the researcher	Journal	Researcher typing notes	Typed notes	Reflexive thematic analysis

4.4 Selection

The participants for this study were selected using purposive sampling technique with a criterion sampling method. In this sampling strategy, “the qualitative researcher handpicks those individuals from the population of interest who have particular experiences and are able to provide a detailed picture of the phenomena

under study" (Tavakol & Sandars, 2014a, p.840). The participants were chosen on the basis of specific criteria that are outlined in table 2.

I chose a convenient sample of two of the ten universities in South Africa that have medical schools, based on the proximity of their geospatial location. My rationale was that in describing the case, it would enrich the data to have participants and documents from more than one institution. Because of the scope of the study, it would not have been feasible to include all ten medical schools. The names of the universities from which study participants were selected as well as documents solicited will not be identified to maintain confidentiality. I will use university A and university B in reporting the findings.

Participant selection is outlined in Table 2 and described for each phase below.

Table 2: Participant selection

Phase	Participants	Criteria
Phase 1a	Practitioners	Registration with the Health Professional Council of South Africa, practising as a medical doctor or psychologist and involved in GAHC.
Phase 1b	Students	Medical students at university A and B, who actively seek to become gender-affirming practitioners.
Phase 2	Medical Educators	Medical educators who are employed at the Health Science faculties at University A and B.

4.4.1 Selection Phase 1

4.4.1.1 Phase 1a: Medical doctors and psychologists who are providing gender-affirming care.

I deliberately tried to find TGD practitioners for inclusion in the sample to give voice to how they became gender-affirming practitioners. They could also potentially provide a unique perspective as both providers and recipients of gender-affirming health care. Participants were purposively sampled from existing informal networks

in the field of GAHC in South Africa in 2019. My sampling approach is confirmed in the literature. Reisner and colleagues argue that inclusion of transgender people is essential to ensure that health-related research and interventions are responsive to the real-life issues that transgender people face (Reisner et al., 2016). Research should be conducted “with” and not “on” transgender populations (Reisner et al., 2016, p. S240). This approach of including TGD people is supported by literature on the ethical aspects of doing research involving TGD people (Adams et al, 2017; Bauer et al, 2019).

The reason for including psychologists is that at the time of data generation (2019-2020) there were very few medical practitioners in South Africa known to provide gender-affirming health care. The psychology profession has been at the forefront of considering ways of providing affirming care to sexually and gender diverse populations in South Africa. This has been demonstrated by the publication in 2017 of the ‘*Practice Guidelines for Psychology Professionals Working With Sexually And Gender-Diverse People’* (Psychological Society of South Africa, 2017).

Inclusion criteria for Phase 1a were registration with the Health Professional Council of South Africa, practising as a medical doctor or psychologist and involved in GAHC.

4.4.1.2 Phase 1b: Medical students

Medical students with an interest in gender diversity and who seek to become gender-affirming practitioners were sampled from two universities. An attempt was made to include medical students who are TGD in the sample. The LGBT student societies at the two universities assisted with finding potential participants. A snowball-sampling strategy was used by asking participants to suggest other students who may be interested in participating (Ramani, 2015). When I asked participants to suggest other students, they obtained permission from those students to share their contact details with me. The initial plan was to focus on students in the senior years of study, but this proved difficult as it was not easy to recruit participants. There were not many students interested in GAHC, secondly few were willing to be interviewed. Medical students are generally very busy and do not have a lot of time to engage in research that they do

not consider relevant. GAHC is not seen as a priority by many medical students, which is why doing this research is important.

Minimum inclusion criteria for Phase 1b were medical students at university A and B, and medical students who actively seek to become gender-affirming practitioners.

I contacted potential participants via email to invite them to participate in the study. When they showed interest, I emailed the study information sheet and consent form to allow them to decide whether to participate in the study (Appendix 3). When they agreed to be interviewed, a time and venue that were convenient for the participant were agreed upon. Informed consent was obtained from participants with a written consent form, and they were informed that they are free to withdraw from the research at any stage. Permission was obtained from university structures at University A and B to interview medical students (phase 1) and medical educators (phase 2).

4.4.1.3 Sample size and data saturation

A sample size of 6–8 practitioners and 6–8 students was envisaged for phase 1. As in narrative inquiry, interviewing is a lengthy process with repeated interviews, a small sample size can be considered adequate (Kim, 2016). The final sample was 6 practitioners and 9 students.

Data saturation is a concept with its roots in grounded theory, that is based in a positivist research paradigm (Varpio et al., 2017). The term has been problematised in Health Professions Education, with Varpio et al. (2017) asking whether theories, data or themes can ever be truly saturated, as there is always potential to discover something new or different with extra data (Varpio et al., 2017). This study is situated in a critical research paradigm, where positivist concepts cannot simply be used uncritically.

Braun & Clarke (2021b) argue that saturation is not a concept compatible with reflexive thematic analysis, because “meaning is generated through interpretation of,

not excavated from, data, and therefore judgements about 'how many' data items, and when to stop data collection, are inescapably situated and subjective" (Braun & Clarke, 2021b).

In this study, the individual narratives were quite different, as each participant had their own unique journey of becoming gender-affirming. With the reflexive thematic analysis there were themes generated that were similar in the different narratives. There was a stage in the data generation and analysis process where we felt that the themes generated would be sufficient to answer the research question. This was guided by the concept of meaning sufficiency, described by Braun & Clarke (2021a) as a useful concept for the point at which to stop data generation in reflexive thematic analysis (Braun & Clarke, 2021a).This then resulted in the final sample of 6 practitioners and 9 students.

4.4.2 Selection Phase 2

4.4.2.1 Medical educators

Eleven medical educators were purposively sampled at university A and B. The sample included medical educators who are involved in teaching communication skills and professionalism. In addition, medical educators in the clinical years were included in the sample as that is when learning practice actually happens. Some of the medical educators included have experience in curriculum design. I was unable to find medical educators who identify as TGD.

Minimum inclusion criteria for phase 2 were medical educators who are employed at the Health Science faculties at University A and B.

4.4.2.2 Sampling of documents

HPCSA documents relating to undergraduate medical curriculum as well as curriculum documents at university A and B relating to the undergraduate medical curriculum, diversity, teaching of professionalism etc. were sampled. For the HPCSA, the existing documents are the Ethics guidelines (Health Professions Council of South Africa, 2016a) and the Core Competencies document (Health Professions Council of South Africa, 2011). Accreditation documentation that the

universities engaged with when the HPCSA did the accreditation visits were requested from university A and B. I was able to access the self-evaluation report template that the institutions completed. I was not able to access the HPCSA accreditation reports as they were regarded as confidential documents by the institutions. Course convenors for the undergraduate medical curriculum provided additional documents.

4.5 Research procedures

4.5.1 Research procedures: Phase 1

I arranged a time and venue that were convenient for the participant for each interview. For the three practitioner participants in Cape Town, this was close to where they live or work. For practitioner participants outside of Cape Town, I planned to travel to where they lived for the initial interview, with follow-up interviews done online. This was possible for two participants. With the third participant, it was difficult to arrange an in-person interview, resulting in the initial interview also done online. For the students, I only managed to do two in-person interviews. As it was during the COVID-19 pandemic in 2020, most students preferred an online interview.

The interview guide for the narrative interviews can be found in Appendix 4. It was constructed to enable the participant to tell their story and was informed by the literature review. For the practitioners (Phase 1a), the initial interview duration varied between 12 and 50 minutes, and follow-up interviews between 7 and 46 minutes. For the students (Phase 1b) the interview duration was between 15 and 38 minutes. All participants were comfortable speaking in English; thus, no translation was required.

The individual narrative interviews were audio-recorded and transcribed. Narrative triggers were used to elicit stories from participants, outlined in Appendix 4. During the interview process, I had to manage tensions relating to my researcher role outlined in the following examples. In the practitioner group, participants T, K and E are prominent figures in GAHC as trans identified professionals. I could listen to their narratives almost as a follower, with awareness of their vast experience. With D, SM and N, who are cisgender practitioners, it was different, as they had been

participants of training in GAHC where I was a trainer, and they viewed me as a leader. We had interacted prior to the interviews when they asked me for advice about specific patients. Being an insider and an outsider was another tension that I had to hold, as described in Chapter 1. During the interviews and analysis, I had to be very aware of these tensions and how it might influence the research process. They accord with Beuthin's description of tensions "between leading and following, being an insider and outsider, influence and neutrality" (Beuthin, 2014, p. 132).

The practitioner participants for phase 1 were invited to keep a journal, reflecting on their journey of becoming. This was discussed at the initial interview, with a request to journal in between interviews. Participants were offered the choice of journaling in an electronic document that can be emailed, or if they preferred a handwritten journal, I offered to provide a book for the journal. I started my data generation in 2019, and then in early 2020 the COVID-19 pandemic started. Even though the participants initially agreed to journal, only one (K) managed to actually do it and sent it to me electronically. This journal was included in the data for Phase 1.

In narrative inquiry there is prolonged engagement. I negotiated the meaning of the stories with the participants by providing validation checks during the process of data generation and analysis (Wang & Geale, 2015). For practitioners, this was after the first and second interview, and again after the analysis for all the interviews. For the students, this was only after a single interview. The feedback received by email was included in the data.

4.5.2 Research procedures Phase 2

For phase 2, the narrative analysis, represented as stories, were presented to a purposive sample of medical educators in a facilitated group engagement. This meeting with the medical educators was held online, as it was during the COVID-19 pandemic. The meeting was facilitated by an experienced colleague from the Health Science Education Department. Prior to the meeting, I shared four research stories (presented in this thesis in Chapters 5 and 6) for pre-reading. At the beginning of the meeting, I presented my initial findings for phase 1 (analysis of narrative, the themes generated from the stories). This was followed by a facilitated discussion, using the

discussion guide that can be found in Appendix 6. The discussion was audio-recorded, and I took field notes. I transcribed the recording myself, to immerse myself in the data.

For the document analysis I studied HPCSA and curriculum documents from university A and B looking for content relevant to GAHC and PIF, based on the literature review, such as marginalised populations, professionalism, and the potential silences, such as limited references to GAHC.

4.5.3 Researcher reflective journal

In qualitative research methodology, the researcher is a key instrument in data generation (McGrath et al., 2018). In narrative inquiry, researchers need to "carefully consider who they are, and who they are becoming, in the research puzzle" (Caine et al., 2013, p. 577). As a narrative researcher, I have reflected on how my background influences the interpretation of the data. I kept a reflective journal during the study (Creswell & Creswell, 2018), to document the PhD journey. It included content on positionality, that was used to write section 1.4 (Narrative beginnings – my own positionality and how this shifted during the PhD journey). In the journal, I documented my observations about the process of data generation and explored how my values and beliefs may have influenced data interpretation. It also included reflections, which form part of the data and have been included in the analysis.

4.6 Data Analyses

4.6.1 Analysis Phase 1: Narrative interviews

Polkinghorne describes two approaches to analysis in narrative inquiry, namely 'analysis of narrative' and 'narrative analysis' (Polkinghorne, 1995). 'Analysis of narrative' is where researchers view stories as 'data' and then analyse those stories for themes that hold across stories. 'Narrative analysis' is where researchers gather descriptions of actions and events as 'data' from which stories are generated (McCormack, 2004). Bleakley describes the two approaches as "thinking about a story and thinking with a story, story as content (structure) vs. story as process (discourse)" (Bleakley, 2005, p. 536). He suggests that medical educators interested

in narrative inquiry can regard this as a productive tension, and that aspects of both approaches can be utilised. I have used aspects of both approaches. Gwyneth James argues that there is no single correct way to analyse data narratively, “diversity characterises narrative inquiry and should not be something we shy away from because of its concomitant complexity; rather it is something to be celebrated” (James, 2017, p. 3114).

I transcribed all the recordings of the interviews myself. Listening to the recordings repeatedly allowed me to become intimately familiar with the data and start to recognise patterns. This was the start of a process of prolonged data immersion (Braun & Clarke, 2019). I analysed these transcripts using narrative analysis. McCormack describes a process of “storying stories” (McCormack, 2004, p. 220) that draws from both kinds of narrative inquiry framework: ‘analysis of narrative’ and ‘narrative analysis’ (Polkinghorne, 1995). I did narrative analysis for all the interviews, and in the end chose five research stories to include in Chapters 5 and 6. The specific stories were chosen for their richness in demonstrating the PIF journey towards being gender affirming. When I struggled with the analysis, it was helpful to work through the meaning of the research stories by using drawings to make sense of a complex process.

In addition to narrative analysis, I looked at common themes throughout the stories, which is more aligned with ‘analysis of narratives’ (Polkinghorne, 1995) to inform the presentation to the medical educators in phase 2. This was done utilising reflexive thematic analysis (Braun & Clarke 2006; 2019). The six steps outlined by Braun and Clarke entail: (a) the researcher familiarises themselves with the data; (b) initial codes are generated, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes and (f) final analysis and write-up of the report. Reflexive thematic analysis is about meaning making and telling stories about the data, with the researcher generating themes through “the creative labour of coding” rather than themes passively emerging from the data (Braun & Clarke, 2019, p. 594).

I initially considered using software for qualitative analysis such as Nvivo to organise the data. Kim stated that software may have limited use for narrative analysis (Kim,

2016). I found that it was sufficient to organise the data in MS Word documents, with colour coding to generate the initial codes.

In narrative inquiry, the larger and smaller contexts in which stories are told are carefully considered. There is attention to both the larger socio-political narratives in the context, and the relationship between researcher and participant (Caine et al., 2013). In considering the larger context, which includes the socio-political aspects, I paid attention to the learning environment at medical school and issues of power in the curriculum.

For the narrative analysis, I initially used an inductive approach, and then complimented it with a deductive approach to look at the research stories through the lens of PIF. This provided more depth to the analysis as I was working towards understanding the case of the process of PIF of a gender-affirming practitioner in a South African context.

4.6.2 Analysis Phase 2

4.6.2.1 Analysis: medical educator group engagement

The medical educator group engagement was a valuable component of this study, as it brought in the perspectives of medical educators in response to the initial findings of phase 1 of the study. The skilful facilitation resulted in meaningful discussion about the realities and barriers to curriculum change. Reflexive thematic analysis was done of the transcript and field notes to theorise about the implications for curriculum change (Braun & Clarke, 2006, 2019). This fed into the analysis presented in Chapter 6 (Findings for objective 2: Medical curriculum).

4.6.2.2 Document analysis

Document analysis is a systematic procedure to review or evaluate documents. Like other qualitative methods, document analysis requires examination and interpretation of data in order to elicit meaning and gain understanding (Bowen, 2009). Bowen argues that researchers should view documents critically, in order to establish the meaning of the document and how its content contributes to the issues being explored (Bowen, 2009). I used the READ approach to document analysis in

health policy research, that includes the following steps: “(1) ready your materials, (2) extract data, (3) analyse data and (4) distil your findings” (Dalglish et al., 2020, p. 1424). This aligned with a critical research paradigm as the document analysis explored how medical schools play a role in constructing power and privilege in society (Hodges, 2014).

For the document analysis, I studied HPCSA and curriculum documents from university A and B, looking for content relevant to GAHC and PIF such as marginalised populations, professionalism, and the potential silences. I did a first-pass document review of the documents outlined in the sampling strategy, to allow me to identify pertinent information and to separate it from that which is not considered as pertinent (Bowen, 2009). Data were extracted into tables, followed by reflexive thematic analysis (Braun & Clarke, 2006, 2019). This involved a careful, more focused re-reading and review of the data to recognise patterns (Bowen, 2009). This included looking with a critical research lens at issues of power within the curriculum. The last step in the READ approach is distilling data. It is described in the article by Dalglish et al. (2020) with an analogy of collecting shells from the beach and preserving “only the best specimens for presentation” (Dalglish et al., 2020, p. 1430). I did this by making a choice about the relevant themes from the document analysis that has been included in Chapter 6.

4.6.3 Researcher reflective journal

Reflexive thematic analysis (Braun & Clarke, 2006, 2019) was used to analyse the reflective journal. The themes fed into the description of my positionality (section 1.4) as well as Chapters 5 and 6.

4.6.4 Case study analysis

For the case study, the different data sources have been combined to describe the case in Chapter 7. This convergence braided the various strands of data together in order to enhance understanding of the case (Baxter & Jack, 2008). The narrative analysis (research stories), analysis of narrative (reflexive thematic analysis), reflexive thematic analysis of phase 2 (medical educator group discussion and document analysis) and the researcher reflective journal contributed to the

description of the context of the case. The case of the process of PIF of a gender-affirming practitioner in a South African context was analysed by bringing together insights gained from phase 1-2. I used a critical pedagogy perspective to look at different aspects of power relations in the case. I found this a difficult process, to move from a more descriptive analysis, ‘this is what the field says’, to a more critical analysis. I had to go back to the research stories and ask questions of the text, looking for the deeper meaning. It took time to conceptualise the case in the end. It was not a straightforward process of bringing the different strands together, rather a messy and complex process. Beuthin (2014) describes her difficulties doing narrative inquiry as “breathing in the mud—a dynamic process in which the researcher moves between the tensions of getting stuck in one moment and finding brilliant presence in the next” (Beuthin, 2014; p. 122). It often felt to me like what Beuthin (2014) described, of breathing through a metaphoric muddiness towards a clearer understanding of the complexities. It was hard for me as a researcher, having been socialised and immersed in a medicalised practice that is very positivist, to move towards a depathologising perspective and a more critical analysis.

4.7 Data safety and monitoring

All written records and audio recordings have been kept securely by me for the duration of the study. The records have been stored on a computer with a protected password for security. Only I as the researcher have access to the data storage. The transcription of data is password protected and when this was sent to my supervisors by email, it was in a password-protected document. When transcripts or research stories were emailed to participants for validation checks, it was password protected.

4.8 Strategies for achieving scientific rigour

How to ensure the rigor of qualitative research has been debated in the literature (Gibbert et al., 2008; Gibbert & Ruigrok, 2010). There are different approaches to describing rigour in case studies, depending on whether the researcher takes a positivist or interpretivist approach (Gibbert & Ruigrok, 2010). With a positivist approach, the labels of construct validity, internal validity, generalisability, or external validity, and reliability are often used whereas with an interpretivist approach, the

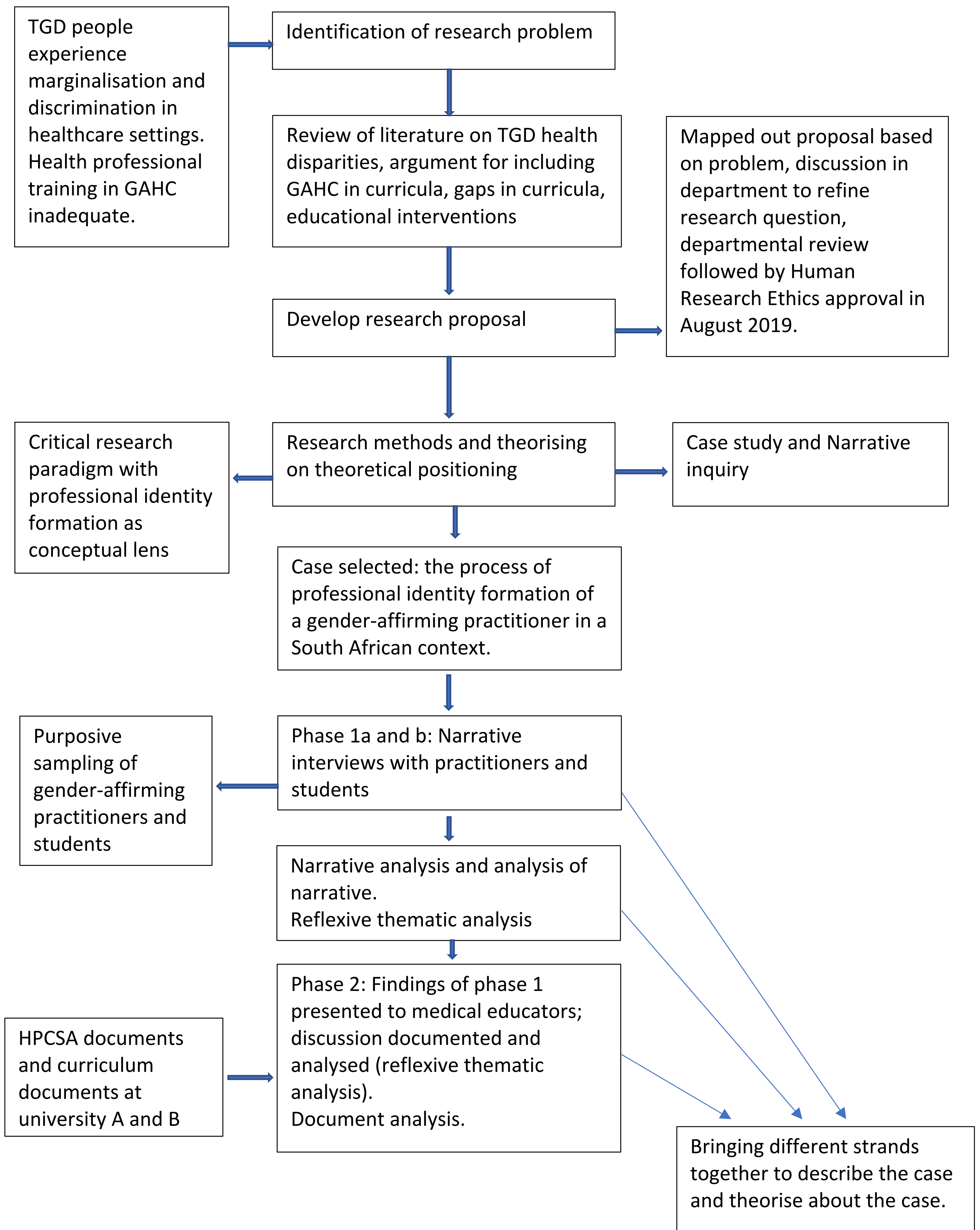
concrete research actions that are necessary to ensure rigor are reported (Gibbert & Ruigrok, 2010). Pratt used the metaphor of trying to fit oval pegs (qualitative criteria for rigor) into round holes (positivist, quantitative criteria for rigor) (Pratt, 2008) to describe these tensions. He also suggested that rigor in case study research could be ensured by ‘‘focusing on the process of fitting,’’ rather than on ‘‘making oval pegs seem rounder, or by making round holes larger or more oval friendly’’ (Pratt, 2008, p. 496).

Qualitative validity means that the researcher employs certain procedures to check for the accuracy of the findings by (Creswell & Creswell, 2018). Other terms used include trustworthiness, authenticity, and credibility (Creswell & Creswell, 2018). For this study, I used the following validity procedures described by Creswell & Creswell (2018):

- Triangulation of data sources was used in order to view and explore the phenomena from multiple perspectives.
- Member-checking: As data got generated and analysed, a process of member checking was used, where participants had the opportunity to discuss and clarify the interpretation of the data and contribute new or additional perspectives. For the student participants (phase 1b) this was only once after the initial analysis whereas for the practitioners (phase 1a) this happened repeatedly over time as the analysis was refined, with between 2 and 4 interactions with each practitioner.
- Using a rich, thick description to convey the findings.
- Clarifying the bias that I bring to the study (positionality discussion in Chapter 1).
- Presenting negative information that appears to run counter to the theme.
- Spending prolonged time in the field to facilitate the development of an in-depth understanding of the phenomenon under study. The practitioners (Phase 1a) were interviewed twice within the study period 2019-2020, followed by member checking after each interview and later during the analysis.
- Using peer debriefing to enhance the accuracy of the account. I had a meeting with a colleague who is a medical educator, to discuss the themes arising from the data.

Qualitative reliability was sought by documenting a clear chain of evidence that allows readers to reconstruct how I went from the initial research questions to reach the final conclusions (Gibbert et al., 2008). A visual audit trail of the research process has been constructed to outline the research steps taken to decide on the case selection, data generation and data analysis, see Figure 5.

Figure 5: Visual audit trail of research process (Source: created by author)



Qualitative generalisation is limited, since the intent of this form of inquiry is not to generalise findings (Creswell & Creswell, 2018). Whereas statistical generalization refers to generalising to a population, analytical generalisation refers to the generalisation from empirical observations to theory, rather than a population (Gibbert & Ruigrok, 2010).

Transferability may be compared with external validity in quantitative research (Ramani & Mann, 2015). Detailed descriptions of the study design and analysis along with reference to relevant literature can help other researchers assess whether the study can be reproduced in their own context or if the results can be transferred to their context (Ramani & Mann, 2015). This case study will not claim to be generalisable, but may contribute to theory around PIF, specifically in the area of GAHC.

Table 3: Measures for scientific rigour

Confirmability	A visual audit trail of the resource process was included as Figure 5. A reflexive research journal was kept by the researcher. Reasons for methodological and analytical choices are explained in the thesis.
Credibility	Data was generated from different sources as outlined in table 1, and triangulated. There was prolonged engagement with participants. Member checking followed the narrative interviews. Peer debriefing.
Dependability	The data generation tools; process of analysis and the generation of the key findings have been made explicit.
Transferability	The study design and analysis has been described in detail.

4.9 Ethical considerations

This research complies with the 2013 update of the 2008 Declaration of Helsinki (World Medical Association, 2013). Ethics approval was obtained from the University of Cape Town Human Research Ethics Committee, reference number 399/2019. The original approval dated 19 August 2019 and the latest renewal dated 15 November 2023 are included as Appendices A and B.

4.9.1 Risks and benefits

The risk of participating in this study was minimal. Although there was provision that if any participant would become emotionally upset during the interview, the interview could be stopped at the participant's request, this was not necessary. It was not necessary for any psychological counselling to be arranged. The potential benefit of the study for participants was having the opportunity to discuss and express their views on a topic that was important to them, to tell their stories about becoming gender-affirming practitioners, and to have the opportunity to contribute to the body of knowledge on this topic. This contribution to thinking about curriculum change may benefit medical students and in the long-term patients (through provision of GAHC).

4.9.2 Potential vulnerability

Vulnerability in research suggests that a person may have additional susceptibility to research-related harm or risk (Biros, 2018). TGD persons may be seen as potentially part of a vulnerable or marginalised population, as the literature describes health and economic disparities (Reisner et al., 2016). Health professionals and medical students comprised the sample. They are not economically disadvantaged or vulnerable in the same way as a TGD person who for example left school due to bullying and is struggling to find employment. The health professionals are on equal footing with me. With students, I was very aware of the issues of power as I conducted the interviews, but this does not imply vulnerability in terms of additional risk for research-related harm (Biros, 2018). I was not involved in teaching or assessing the student participants. TGD health professionals and students included in the sample have therefore not been regarded as vulnerable.

4.9.3 Privacy and confidentiality

Narrative researchers have an ethical duty to protect the privacy and dignity of participants whose lives we study and to protect them from any harm that may ensue from their participation (Josselson, 2012). Anonymity is on a continuum with fully anonymous on the one extreme, to very nearly identifiable (Scott, 2005). Anonymising can happen in different areas (Saunders et al., 2015), such as participant's names, places, religious and cultural backgrounds, occupation, and

family relationships. Discussion between researchers and research participants is essential in order to negotiate levels of anonymizing or suspension thereof (Saunders et al., 2015). Vincent (2018) points out that when including TGD participants, unique situations may arise in relation to anonymity/recognisability in research and advises that researchers consider the risks and benefits of visibility on an individual basis, in dialogue with participants (Vincent, 2018).

I have been mindful that I should not assume that every participant wants complete anonymity. I informed participants that names would not be used in the research report, and that they could choose a letter or letters e.g., initial(s) to be used. I discussed with participants whether biographical details in the narratives that could identify them needed to be changed in the narrative analysis. Most participants were comfortable for their narratives to remain as is with potential identifying details, while one student insisted on complete anonymity.

As the participants were drawn from a small group of gender-affirming practitioners and students, I did not include a table with the participants' age, race, profession, etc. to avoid the risk of a participant (especially a TGD participant) being potentially identifiable.

For the group discussion, participants have not been identified in the reporting of the data in Chapter 6. In the consent form, it was outlined:

> For the group discussion, the researcher cannot guarantee that participants' confidentiality will be maintained as other participants in the group may disclose what was discussed with persons outside the group. The researcher will request that focus group members respect each other's confidentiality by not speaking to others about matters raised in the group.

The content of the discussion did not include personal information but rather participant views about curriculum.

4.9.4 Re-imbursement

The study was planned with the intention that there will be no monetary benefits for participants. For the in-person interviews, refreshments were provided. For the

facilitated group engagement with the medical educators, the initial plan was to have this at a venue where lunch and tea would be provided. This was not possible as it was during the COVID-19 pandemic. Permission was obtained from the University of Cape Town Human Research Ethics Committee for a R500 gift voucher for an online shop (Takealot) to be sent to the participants following the engagement, in lieu of a meal.

4.9.5 Ethical implications of the research methods

In addition to the ethical aspects discussed above, there are specific ethical implications of narrative inquiry and reflexive thematic analysis. In narrative inquiry, an ethical relationship between the researcher and the participant is essential, as narrative inquiry is relational (Kim, 2016). This requires “respecting the dignity of our participants and honouring the sacredness of their humanity as we develop trustworthy relationships with them (Kim, 2016, p. 104). With reflexive thematic analysis, ethical aspects to consider include the power relationship between the researcher and participant, the researcher’s values as well as how the researcher relates to and represents participants (Braun & Clarke, 2021a). This requires a reflexive approach, which I followed in the research process, by paying attention to the relationships with participants and how they are represented in the research stories and themes that were generated.

4.10 Summary

This chapter provided a detailed description of using case study and narrative inquiry as complementary methodological frameworks to investigate my research question. The next two chapters will look at the findings, related to the two research objectives.

Chapter 5 Findings for Objective 1: Professional Identity formation of a gender-affirming practitioner

5.1 Introduction to the chapter

The overall aim of this research is to explore how medical curriculum change could enable the professional identity formation of a gender-affirming practitioner. The focus of this chapter is the first objective of this research:

Objective 1: To analyse the process of professional identity formation of gender-affirming healthcare practitioners and students using narrative interviews.

The first part of the chapter consists of three research stories from the practitioner group of participants. Out of the six practitioner stories, I chose the three that best demonstrated the journey of becoming a gender-affirming practitioner and that had the most detailed description of the different aspects of their journeys. The second part describes the themes relevant to this objective, that were generated by "analysis of narrative", of the interviews from the six practitioners and nine students. The themes are: "Becoming gender-affirming is a journey of ongoing learning;" "Affirming in every space"; "Learning from lived experiences" and "Learning online". The themes will be discussed through the lens of PIF and in the context of the literature, followed by a conclusion to the chapter.

5.2 Research stories

5.2.1 Research story 1: "How to give a damn"

Introduction

This research story follows T's journey from her experiences as a medical student, to accessing care herself as a trans woman, to practicing as an affirming doctor and teaching medical students. T was assigned male at birth, and as a medical student and as young doctor presented as male. When she was already a practicing doctor, she came to the gradual realisation that she had to access gender affirmation in order to survive. T has strong political views, grounded in a human rights

perspective, and is passionate about changing the perspectives of health professionals to be gender-affirming. The context of the story is South Africa in the second decade of this millennium, where the culture of medical schools and the medical field more broadly is still quite conservative with little space for diversity.

Medical school experiences

I remember as a student spending a lot of time being afraid, and worrying what was going to happen next, what we would get blamed for next, which professor was going to rip us apart at the ward rounds, because we've been on call for thirty-six hours, you are barely coherent enough to string two sentences together let alone a case presentation of a patient in front of a grand ward round. I remember the system being very abusive, not just to patients, but to us as medical students.

I had liberal, progressive political views no-one else in my class had. I was pro-choice, I supported the idea that people deserved to be treated with dignity no matter what background, orientation, or identity they have. I remember being ostracized because of that, as someone who was read as cis male at that stage. The power dynamic and patriarchy were very firmly entrenched in the ethos at medical school, where old male professors could say whatever they wanted to young female students. I remember sitting in a surgery tutorial, a professor emeritus would pick one of the little blonde girls from the group of students, and say to her, "you look like you are pretty well cut out to be an anaesthetist one day". You know, I remember some of the female students complaining that when they were assisting in theatre, people would move them around as if they were furniture, just pick them up and move them.

We had maybe a handful of lectures in humanities, and we didn't have the time for it, we did not think it was important, it wasn't cool, we didn't know what we were doing there. That idea that the humanity gets beaten out of you in med school was absolutely what I experienced.

I can remember, in six years of med school, I was taught one sentence about trans patients, formally in a lecture in fifth year. And that was from one of the urology lecturers, and this was in response to a question that someone had asked, from the class, and I think there was a very brief discussion around, I don't know if it was about gay men, and one of the students put up their hand and asked, "what about trans patients?", and I can't remember the language they used asking the question. I

do remember the lecturer saying, “surgery doesn’t help those people”. I remember that was it, that was all I was taught about trans patients. We were not really taught the ins and outs of any healthcare needs pertinent to the LGBTI population.

Inner dialogues – looking in the mirror.

I think certainly as I became closer to the point of coming out myself, of going through an inner dialogue where I had to learn and understand these truths about myself in terms of my gender identity, obviously I recognized that there were some definite deficits in my understanding as a clinician of how to approach and how to manage such a patient, and those notions were all reinforced when I consulted with other professionals and specialists as a patient. And initially my desire in seeking help from outside sources for my own transition was really informed by this idea that I was starting to understand who I am, for the first time I really wanted to take some care of myself, look after myself, I wanted to do things sort of in inverted commas, “by the book”, and the best way to do this is not to manage my own transition.

Honestly for me, there was still so much stigma and pathologisation. It took me so long, because I couldn't really look in the mirror and say, "I'm one of those people", because it would have meant that I was broken and I would have to take action that could jeopardise my livelihood, relationships etc. I went through a period where I tried to convince myself that I was ok with masculinity even if I didn't identify wholly with it. But I wasn't doing well, and I had to come to terms with the fact that no part of masculinity was comfortable for or applicable to me, and that I needed to access gender-affirmation if I was to survive - it was literally a matter of life and death. Then there's the whole other side of this coin which is the imposter syndrome - am I queer enough/trans enough/have I suffered enough to warrant or earn my label and my intervention - I struggled with that at the time. In retrospect, I recognise that I did in fact have intense dysphoria - I think my realisation only came after the process of coming out. But at the time that I was still trying to find reasons ‘not’ to consider transition, I definitely tried to tell myself that I wasn't dysphoric. I think it's only later in this journey that I got to interrogating the pathologisation. Even if I didn't pathologise the trans patients I treated before coming out, I still had the internalised baggage of medical stigma.

It was a gradual realization – I don’t think it’s an end point; because there is so much stigma and so much conditioning, trans people especially of my generation must wage a constant battle against internalised transphobia.

There were many times that I didn't care for myself or love myself – being different in a way that was not spoken about or seen as acceptable makes one feel broken and without value. When the pieces had fallen into place enough for me to understand why I had felt different through my life, I wanted to give myself a chance to grow into the best form of me that I could, someone who would be deserving of care and kindness.

There's a double standard at play, because I wouldn't have thought someone else to be broken/sick because of their identity – but there is a tension between how we are conditioned in our formative years, and the actual perspectives and judgements we make (or choose not to make) through our ethical and intellectual lenses. Although my perspective is and always was one of depathologisation; but despite holding that position, I still found it hard not to see myself without stigma/pathologisation.

Horrendous experiences of accessing gender-affirming healthcare

When the time came for me to access medical care to affirm my gender, I was deeply disappointed and hurt. My interactions with specialists in the field of psychiatry and endocrinology, general practitioners, as well as psychologists, were just supremely undermining, condescending and even abusive. And I can still remember coming to the very stark realization, that it would be safer for me, and in my best interest, to look after my own medical care and not to trust anyone else with it. I did not feel psychologically safe and did not trust the medical knowledge of the professionals I interacted with.

I had a horrendous experience visiting a general practitioner. I went to him because everyone knew him, because he gave out prescriptions for hormones without too much difficulty. He was a member of the LGBTQIA community. He was not trans-identified or anything like that, but his idea of what constituted trans experience was very, I want to say textbook, it did not account for any individual variation. I remember my first consultation with him, when you walk into the reception office, you pay before you even see the doctor. Then you go in to see him, I think I sent an email ahead of time, to say, I am booking a consult for this reason, and he had my file in front of him and he said, what can I do for you, and I said I sent you an email, and he said, you want hormones, or something like that. And my first experience is that before he asked me anything about myself, before I even had a chance to speak, he stood up, and leaned over the desk and reached across, and touched my

face and turned it, and peered at my skin. And he said, "O yes, you have great pore structure, you will make a fine woman." And that was my first experience. And it was even worse when I came for a follow-up. He didn't ask me about side-effects, he didn't ask me how the hormones were going, he didn't ask how anything, how I was doing, I could barely get a word in edgewise. So, no, it was affirming in that I got a prescription out of it, but it was absolutely not an affirming experience. It gave no respect to who I was, what I was going through, you know my identity was completely lost in that space.

I'm so sure, out of all the shitty experiences, pardon my French, that I had with doctors, with specialists, with the psychiatrist, the endocrinologist, the GP, I'm sure that they all thought they were doing a wonderful service to these poor helpless trans people, and you know I sincerely want to believe that they were not malicious, and that they were not actively trying to damage me or anyone else, but they were ignorant about affirming care. When I reflected, I was able to recognise that the behaviour of the health care professionals I had seen was a reflection of a flawed system as a whole, and that the same sort of actions could have been perpetrated by just about any health care professional. Of course, individual attitudes and prejudice are real, but in my instance, I think that the professionals I saw were good people with bad ideas.

Through interactions with all of these healthcare providers, deeming that I was a medical professional and that I had access to some resources, I took it upon myself to educate myself, and that really was what helped me to understand that the other doctors I was seeing were not necessarily as skilled or as competent as I wanted to believe they were. It prompted a lot of reflection on my part, and I thought, well, if I am struggling to get access to good care, and I am not just privileged because of my social background and my race and whatever else, because I have a medical degree behind my name, how much more difficult it must be for other patients. Who was looking after them? Where do they go, and what kind of treatment are they getting? I really felt like I had this imperative, firstly in order to be able to look after myself, but also to hopefully be able to someday provide a better experience to other people going through this, or their own journeys, let me say, to learn and to grow, and I had to do it independently.

Obviously, I wanted to know if the treatment I was getting from the other doctors was up to standard, if it was safe, if it was the best possible treatment that I could be on, I

wanted to know what best practices were in terms of monitoring, and the specific medications, and I had not been taught any of that in Med school, I had to look for it. I soon figured out that every doctor I came across had a different approach, they advocated different medications, and different sort of algorithms for treating this and I realised there wasn't a standard, and from there I started looking for resources, through the internet to see what was happening overseas. I started looking up what's happening at Fenway Health, what's happening at Callen Lorde, what's happening at the Centre of Excellence at UCSF [University of California San Francisco], and that was really the starting point.

Practicing before coming out

I remember before I came out, I was still in private practice in Johannesburg, and I had someone who knew that I was trans, referred a patient to me even though I wasn't out yet, and I saw this patient in the rooms that I was working in. And I remember my first encounter with this patient, just that they had been sort of exceedingly fearful, and exceedingly anxious, and exceedingly distrustful. I wasn't out yet, so it was not like I could say to them, "you know what, I understand what you are going through, because I'm also trans". I just remember, having this reflection, around how do I make this patient feel safe, like they're not going to be judged, like you know whatever it is they have encountered elsewhere, whatever stories they have heard from other people, that none of it is going to happen to them in this consulting room. I am going to do my best to make sure they get access to what they need and that they do it safely and they do it without their dignity and respect being compromised. And I remember, I saw that patient a couple more times before I came out, follow-up visits and everything, and I can remember the feedback, the just very tangible relief from this patient when they realised that this doctor was kind of not out to get them, they did not have to prove their identity, there was no gatekeeping, they did not have to jump through a bunch of hoops and wait for months and months in order to get access to hormones.

It was challenging, because I thought the most powerful tool that I have, isn't available to me, because of my circumstances, but by that time I had already had a few run-ins with the medical establishment. I remember being terrified going for that endocrinology appointment, going for that psychiatry appointment, I was absolutely terrified, I did not know what to do with myself, so I knew what it was like on the other side of the desk, and I was sensitive to that, and I really had to look for whatever ways I could signal to a patient that you are safe now, without being condescending

to them or patronising them. And it is challenging, because at that time I was presenting as what people must have read as a cisgender male. I wouldn't trust a cis man with my healthcare needs, and I don't know that I could really expect a patient to.

Practicing as an openly trans doctor

I saw a patient in my rooms, and this patient came in and they were just very scared and very anxious and did not know what to expect, and they brought their best friend with them, and they were sort of visibly surprised at sort of how easy the consultation was going. I spend a lot of time with patients especially on their first consult, and it's not like digging into their history and how did you know you were trans, that sort of thing, it's more about informing them and educating them and empowering them in the process. I said to this patient at some point, so what's going to happen now is I'm going to ask you some questions about your family history, any chronic illnesses, what medications you use. I said, I'm going to do an examination with you, and give you a request form for some blood tests, and I said, I need you to do the blood tests and I need you to do them soon, but I'm not holding it as a barrier in front of you for accessing hormones, if you want to walk out of my office today with a prescription for your hormones you can do it, and this patient started crying when I said that and it just kind of melted me in that way. I feel like I've been doing this for so long now already, and it just kind of took me all the way back to that first experience. Just that relief when a patient understands that they are not interacting with a system that is necessarily out to harm them, or questions them or interrogates them, all that anxiety just floods away.

Teaching at medical school – changing perspectives.

I'm in a position now where I have access to medical students, during their undergraduate programme. And the feedback I have received from those sessions already, I've got students who said that just by being in that space during the workshop, they've re-examined some of their opinions, they have changed some of their perspectives. It's just because it's never been presented to them before. I've spent a lot of time thinking about how you can get through to people, because I know that, if you have to go look up how to prescribe hormones for a trans patient, it is relatively easy. What you can't go and look up, is how to give a damn about them, how to be a compassionate doctor. I think that education is important in forging gender-affirming professionals and should really hinge around why should you stand up for the marginalized patient, why should you care about the trans patient, why do

you need to be a compassionate and caring doctor towards that particular group of people, and why is it your business even if you do not identify as part of that community. If you can lay that groundwork, then not only do you ensure that when the time comes, that doctor will be able to have the necessary resources to find the latest up to date information, but you also account for the reality that trans patients need so much more than gender-affirming care. Trans patients get into motor vehicle accidents, trans patients have hypertension or diabetes, or the common cold. Trans patients can show up at a health facility for any number of reasons, and it's in those settings that I really feel that the potential for damage is like supremely, extraordinarily high. Being an affirming practitioner is about being affirming in every space and every sphere and recognizing that the needs extend beyond those that are specifically gender related.

Reflection on the ongoing journey becoming a gender-affirming practitioner.
I see this as an ongoing process. You know the language that we were using when I came out, is dramatically different to the language that we use today. And you know terms like MTF and FTM, were being thrown around without flinching an eyelid then, and now we are at a point where we don't talk like that anymore and we realise that it is harmful and damaging. I don't think that becoming a gender-affirming practitioner is as much a destination as it is a choice of journey that you're on. There is a responsibility that comes with it. So, there's a lot of growth and a lot of change. And you know I think, in my mind that kind of separates a gender-affirming practitioner from someone who willingly prescribes hormones.

5.2.2 Analysis of research story 1

This is a multi-layered story of becoming. There is the individual journey of affirming herself and deciding to access GAHC. This is not a linear journey, rather it has been very difficult to face the reality that accessing GAHC is the only possible way to survive. Then there is the professional journey, that starts as a medical student with strong political views.

The story happens in a context where trans identities have been pathologised, where society and the medical world often regard trans people as "broken" and needing to be "fixed". T had to go through an inner journey to be able to look at herself in the mirror and acknowledge her trans identity. It was a journey that took a long time. Her

description that initially she could not look in the mirror and say, "I'm one of those people", contains the language of othering, of 'those people' meaning people who are broken. She had to fight hard against internalised stigma and transphobia to come to a place where she could look at herself with kind eyes and become more affirming of herself. This had to happen before she could make the decision to access GAHC.

What this part of the story tells us is that there is an inner journey of confronting stigma and pathologisation, and for a health professional this includes doing the hard work of confronting the prejudice prevalent in one's own profession. It is difficult to completely separate the individual identity formation journey from the PIF of an affirming practitioner; it appears to be intertwined. T has first-hand experience of the difficult journey of becoming more affirming towards herself, and of accessing GAHC. She experienced it in her own skin. This embodiment gives her a unique perspective, where she can really identify with and understand the experience of TGD patients who come to seek care, and even their experiences before they access care.

T is very aware of her own positionality, coming from a privileged background and having a medical degree, and that there are many TGD people who have an even bigger struggle to access GAHC. She is privileged in several aspects. Economically, she could afford to access private healthcare in a country where access to GAHC in the public sector is very limited. She had the medical knowledge to be able to be critical of the care that she received, and to know where to find information on GAHC in other countries. She had internet access to search for that information. Many TGD people in South Africa do not have access to GAHC at all or do not have much choice but to accept the care they receive even if it is not provided in an affirming way.

T's very painful experiences of trying to access GAHC acted as a motivation to learn more and become more skilled at providing an affirming experience for patients. She could conceptualise what an affirming experience would be for herself and was able to measure the care that she experienced against her own "yardstick" to judge it as inadequate. Her experience where the doctor did not respect her, where she felt that

her “identity was completely lost in that space” contrasts with her desire to provide care where the patient’s dignity is not comprised. She has deeply reflected on her experiences and is able to place it in a bigger context of “a flawed system” rather than blaming individual health professionals. Her experiences also inspire her to want to change the system through educating medical students.

Her PIF journey as an affirming practitioner started even before entering medical school. She describes herself as a student who had “liberal, progressive political views no-one else in my class had”. This resulted in her not fitting in with the conservative medical school environment; there was dissonance with the dominant culture of patriarchy. Her perspective that all people deserved to be treated with dignity is the foundation of an affirming attitude to all patients. She specifically mentions being pro-choice. This is an example of an attitude of respecting patient rights to make their own decisions about their bodies, without judgment, which has some parallels with GAHC. At medical school there were no positive influences to shape her PIF as an affirming practitioner. On the contrary, she described that her experience was that “the humanity is beaten out of you”.

As a practitioner, the journey towards becoming more affirming included two aspects, namely, how to create an affirming environment where a patient feels safe, and the knowledge of how to provide GAHC. T had a deep understanding of how to create an affirming environment, based on her experience of knowing “what it was like on the other side of the desk”. This entails meeting the patient where they are, as a human being and not as someone with a pathology. The positive feedback and appreciation from patients indicate that this is a successful approach. She had to search for information on GAHC internationally, as there were no local guidelines and the practitioners that she had consulted adopted very different approaches. The knowledge aspect was therefore a bigger learning curve for T.

There appears to be a difference in the way that she was able to be affirming in a consultation before coming out compared to when she was open about being transgender. Initially she tried to subtly signal to patients that they are safe, without bringing her own gender identity into the consultation. After she came out as transgender, there could be greater authenticity, with patients knowing that T has

personal experience even before they come to see her. She could bring her whole self to the consultation and talk openly about being transgender. This brings a special quality to the consultation that may not be present in a consultation with a cisgender practitioner. The concept of signalling to patients that they are safe implies an acute awareness from T's experience that TGD patients often feel unsafe in a consultation.

Her identity as a gender-affirming practitioner includes a component of teaching others about GAHC. As she is personally invested in improving care for TGD people, she wants students to understand the importance of an affirming attitude. She brings her whole self to the teaching encounter, which has a significant impact on the students. Through teaching and reflecting on teaching, she learns to articulate her views in such a way that it can change perceptions.

T has a strong political stance that TGD people are deserving of care and need to be affirmed and not judged. It is about how we as health professionals view patients, and about the power relationship in the consultation. She emphasises that she does not expect patients to "prove their identity", she provides information and empowers them. She is strongly opposed to a gatekeeping approach and aims to facilitate access to safe and respectful care.

Regarding the process of becoming an affirming practitioner, T warns us that it is not a destination, but rather "a choice of journey that you're on". It requires an openness to keep on learning and expanding our understanding. An example of this is that as language evolves in this field, one needs to keep up to date. From T's perspective, there appears to be a position of not being affirming, but willing to prescribe hormones, which is different from a practitioner who is transphobic and would not assist with care at all. There is the ideal of a practitioner who would be gender-affirming in all contexts, and people are on different points in their journey towards that ideal. Each practitioner would have their own unique journey.

What does this story bring that is new? The process of becoming a gender-affirming practitioner requires confronting pathologising perspectives, to come to a place where TGD people can be seen for who they are. This story provides a rich

description of what a gender-affirming approach means, both from the perspective of accessing and providing care. For a TG practitioner, their own experience can provide a depth of understanding that adds a special dimension to a consultation.

Drawing this journey, it starts with a picture of looking in a mirror, then a consultation where the patient is not really seen, with a power differential, then a consultation where the patient is really seen, with a focus on reducing the power differential, and then teaching others to really see. The use of drawings was an attempt to make sense of a complex process. This is a representation that may make the process appear more linear than it is.

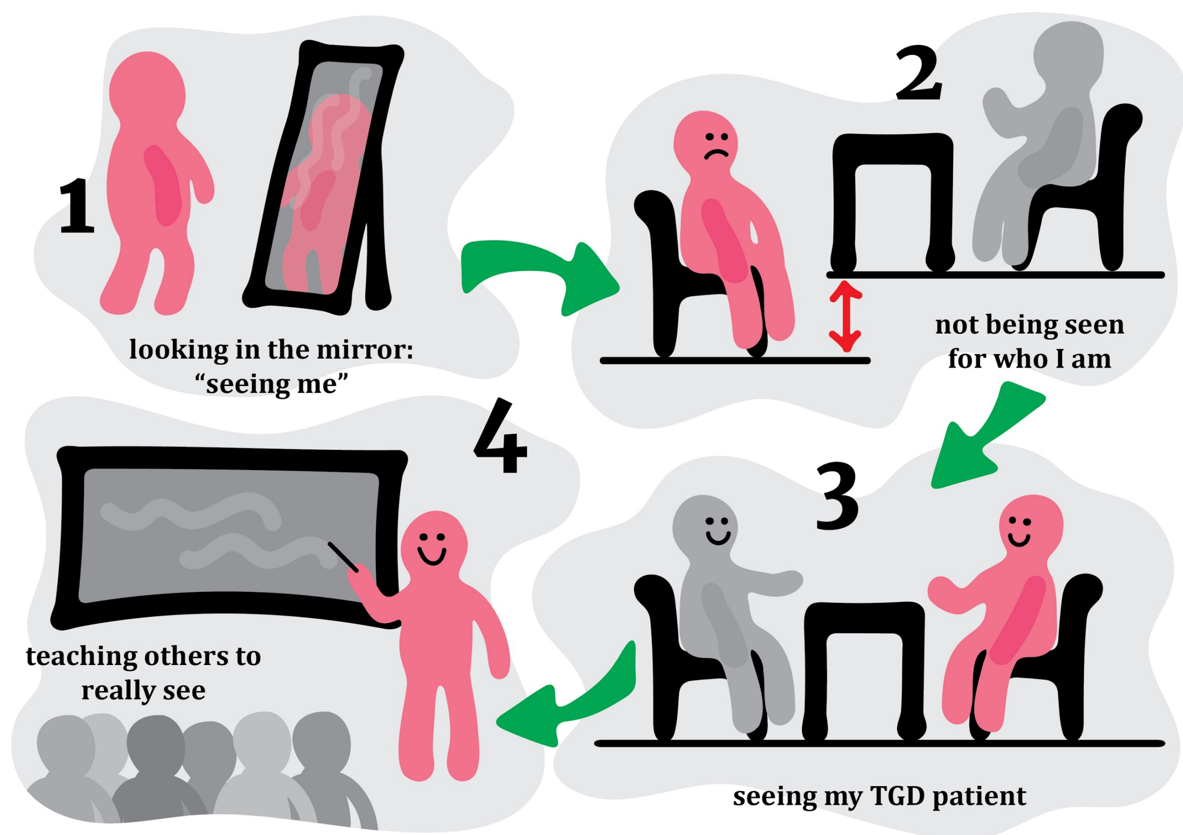


Figure 6: Drawing of research story 1.
Source: Graphic design by Suki Lock of Jagged Daisy**.**

I will complement the inductive approach in the analysis of this story with a deductive approach, looking through the lens of PIF. PIF has been described as happening at both an individual and socio-contextual level (Jarvis-Selinger et al., 2012), that cannot be neatly separated. I will explore the individual aspect using the RToP as framework (Radha Krishna & Alsuwaigh, 2015).

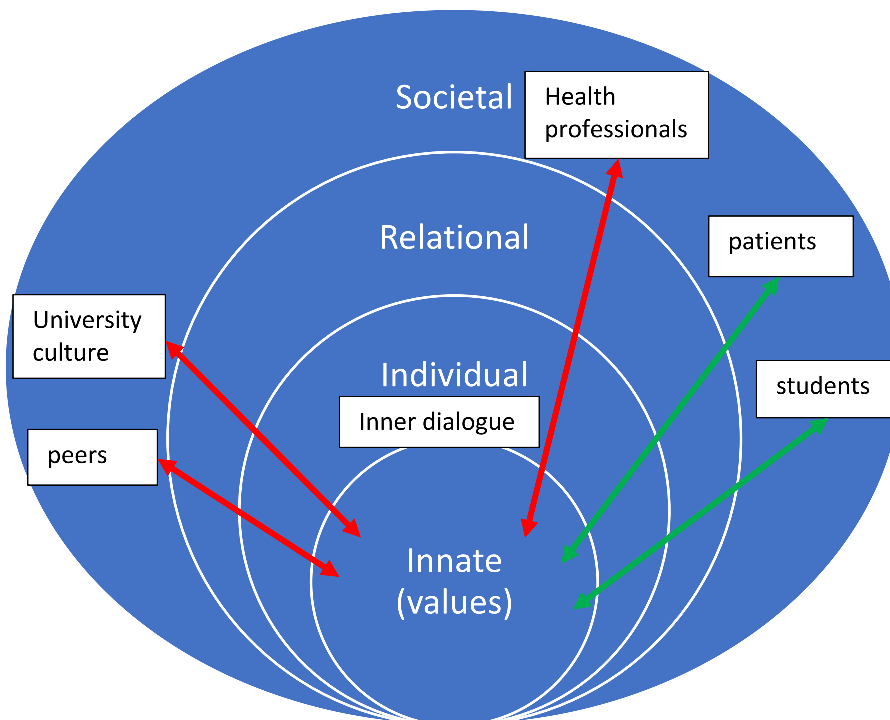


Figure 7: Tensions and alignment between rings in the Ring Theory of Personhood for story 1.

Red arrows indicate tension and green arrows, alignment.

Source: author added to the original graphic by (Radha Krishna & Alsuwaigh, 2015).

As a medical student, T experienced tension between the innate ring (own values) and the societal ring (relationships with peers and the university culture). Her own values of dignity for all patients, and respectful non-patriarchal relationships in the learning environment did not align with her experience of being ostracised by her peers because of her liberal views and being afraid of potential abusive behaviour of professors.

Before coming out, she describes an inner dialogue, which would fall in the individual ring of the RToP. This a significant part of her individual identity formation, coming to understand and accept who she is. This entailed an inner journey to be able to look at herself in the mirror and acknowledge her trans identity, to confront internalised stigma.

When accessing healthcare, T experienced tension between her values and the attitudes of health professionals in her interactions with them. She had a clear idea of what she expected GAHC to be, and her expectations were not met. In the process of PIF, negative experiences can be learning moments, with reflection on how not to behave (Koh et al., 2023). For T, it also influenced her journey to decide to look after her own medical care.

As a practitioner, in her interaction with patients there was alignment between the innate ring and societal ring, as indicated with the green arrow. She was able to provide an affirming space where patients feel respected, and she could sense the relief from patients. The contrast is stark between the horrible care that she experienced and the respectful, affirming care that she is now able to offer to patients.

In her interaction with students, she is in a position of power and able to influence student perspectives. What she teaches them aligns with her values. She emphasises the attitudinal aspect, which forms part of the professional identity of an affirming practitioner, to be compassionate and provide respectful, non-judgmental care. She regards this as much more important than the knowledge of how to prescribe hormones. The skill of being affirming is relevant in every healthcare setting, not only when providing specific gender-affirming care.

The socio-contextual approach views PIF as taking place in a social context (Mount et al., 2022). In this particular research story, there was no local community of practice (Lave & Wenger, 1991) that T could become part of in learning how to become a gender-affirming practitioner. The local context was that of ignorance of how to provide proper GAHC. T had to find information online from international organisations that provided gender-affirming care.

What this analysis adds, is a perspective on T’s individual journey, where an inner dialogue as well as many experiences of dissonance contributed to her growth as an affirming practitioner. She could come to a place where there is alignment, where she can live her values authentically.

5.2.3 Research story 2: "I was not a human; I was an exam question."

Introduction

This research story follows E's journey as a transgender psychologist from being a student, to practicing as a psychologist, his experiences of accessing care, coming out to patients, to doing training in GAHC. E was assigned female at birth, and as a psychology student presented as female. As a student, he identified as queer and was outspoken about the psychology curriculum being silent about "queerness". He worked as an academic and as a psychologist following graduation, and transitioned when he was already working. The context of the story is South Africa in the second decade of this millennium, with attitudes in many health care spaces still very conservative and not affirming of trans identities. This participant uses strong language, which has been retained as it demonstrates the strong emotion when he tells his story.

> **Student years – being critical of the curriculum.**
>
> When I studied psychology, queerness in general did not feature in the curriculum, never mind gender. It was a very global south, community psychology-based master's course, with a critical and decolonial approach that raised our awareness of power. I was a very queer and out student at the time, so I experienced power all the time, I found it so I could push back against it. I was critical about what was taught, how things were spoken about, how people were spoken about. So, for example pointing out the lack of general queer existence in reference material in coursework, that would be one thing. Being very critical of the academic project, I guess.
>
> **My own transition as part of my learning**
>
> When I started my private practice, my very first two patients were transgender, and over the years most of my practice has been with transgender and gender diverse patients. That's had its own learning curve. Learning as I went along, hands-on, seeing what works, and making mistakes. One thing this work has taught me was the importance of authenticity, like saying when you don't know, or admitting to your mistakes. One is always becoming, never at a point of arriving.
>
> My own journey was part of my learning and coming out as transgender myself really shaped the way I think about identity affirming work in general. In terms of my own transition, that shift from it's not an illness, right, and thinking about pathology in that

way, as perceived or understood as an illness, really made an impact for me. It's not an illness, it's an identity, and there are no other ways of keeping it at bay. In those early years, early attempts of mine were not appropriate because there is no fixing and there is no mitigating the fact of it.

Sometimes the diagnostic label can cloud your view of the 'human'. So, I think what is important for me is that you see the human first. The diagnostic labels are waypoints to helping people make sense of themselves and their interactions with the world, but they should never supersede humanity and identity.

Experiences of accessing healthcare – from horrible to amazing

As a trans patient, whenever you seek healthcare from a new professional, a new provider, there is always great anxiety around how they will treat you, will they believe you, will you need to perform a certain thing, do you need to be a certain kind of trans, because some doctors are fucked up like that.

The first time I consulted someone for surgery in 2018 was a horrible experience. I attended an outpatient clinic. I sat with all the older women with their breast cancer, and spent the whole morning with them, very nervous, very hatchling trans boy, finally got to see the plastic surgery registrar, who I then first had to educate on what transgender means, and she was clearly shaken. After we had done the consultation, she called the consultant, who came in, also bringing in a student. Of course, she asked if she could bring in a student, and I being an academic at the time, said of course you can bring in the student. Well, that consultant then turned me into a five-point exam question for the poor student, who did not know where to put her head, and like literally, this is an exam question, what do you need to look for when seeing a trans patient who wants surgery? As the student stumbled through the answers, the doctor in charge gave her the answers, but she got it wrong! So, I had to correct her! …which she obviously didn't like. So, by this stage I was close to tears, and feeling really dehumanised, and then after all of this she was like, but we won't do it anyway, because you need to lose weight, So, I was like, but why? She just said, no, we're not going to do it, you can come back in three months and then we can see again. I walked out of there, completely fucked, and I decided I'll save up for private surgery, I'm not going to put myself through that humiliation. That was insane, and it was just for me, it just highlighted just how much emotional labour is involved in these things. The biggest thing that I left with, was, I was not a human, I was an exam question. What pissed me off about it so much, even more than just hurting

me, in my opinion it happened because I had asked questions and pushed back, which I tend to do, but which is your right as a patient. It frustrates me that I, knowing that it is my right, left feeling like that. What happens to people with less education, people who just don't feel like they have the power in the moment to push back?

My experience with my GP was very different. I was very lucky with my GP, and with the surgeon who eventually did my top surgery, who didn't ask any questions, that were not related to the surgery. No weird, uncomfortable questions, like about my genitals. This GP identifies very strongly as a feminist, Muslim woman who was not very religious, that's her professional identity. And because of that identity, I believe that made her open to listening.

One of my friends started using hormones a month before me. So, he was the first hormone person seen by this GP, and I was like, dude, you are going to take me to this person too. So, the two of us went. By now she knew about trans people. I remember that first consultation, the two of us sitting there, probably for half an hour, just talking about our own research that we've done, online, but also talking to other people about dosages, starting dose and increasing, and also with regards to the bloods, sort of what do you need to look for. It was an amazing experience because she is quite committed to having a feminist approach, supporting empowerment of people marginalised by patriarchy, and she is quite open about it. We managed to leverage that a bit in our favour, but once she started learning, she actually got quite into it and intrigued by it. Two months later our friend, who is a very androgenous-looking lesbian, but identifies as cisgender, went to see the same doctor, and apparently the doctor when she walked in said to her, so, do you also want to be on hormones? Because she started reading, she became aware of our existence. So, that person didn't want hormones, and the doctor's lesson for that day was "don't assume".

Learning about GAHC in a journal club

I got information about GAHC from colleagues and supervisors who also worked with or had an interest in working with queer people in general. A group of us actually started a journal club discussing articles related to gender diversity. All of us referred to the WPATH guidelines at the time, and also some resources that GenderDynamiX has available online.

Coming out to clients – being authentic in the room

When you have to come out to your patients, because you have to if you transition, as your voice changes, you get facial hair, and these people see you every week, so they are going to notice it. So, at some point, when my voice started changing, about two or three months in, I realised I had to come out to my patients, and I had a coming out week. At the start of each session I was like, right, so before we start, this is what's happening, this is what you can expect, and it was such an interesting moment, in all of their processes, because it allowed for a deeper authenticity, a deeper authentic connection. There's something about that vulnerability, the therapist's vulnerability in terms of this is who I am, that really does something for the relationship, and so that shifted my approach to therapy a lot, in terms of what does it mean to be authentic in the room, what does it mean to be an authentic therapist?

There is always that sense that when a person comes in, they think you might expect a sort of a performance of a certain identity, so what I do, at the very beginning, I make it very clear that this is not an assessment, I will not in fact be assessing you, that's not how I work, so you don't have to feel like you have to prove anything. It is actually quite noticeable, most of the time, after saying that sentence, how people just kind of sigh, breathe a sigh of relief, and really get into it. It actually opens the door for talking about previous experiences with health care providers that might have been traumatic. That happens often, where you open with that statement, and then the rest of the session is devoted to sort of debriefing past trauma. I think, that's a simple thing that I do that's really useful, it seems to help people just chill out a lot. This is not a test. I am in no position to tell you whether you are trans enough for anything.

The other shift that I think has also been brought about as a result of my own experience, is increasingly focusing on experiences of gender euphoria as a marker of gender diversity, rather than gender dysphoria. I suspect we hide a lot, we learn to supress a lot of our dysphoria, because we need to survive life, essentially, and because it can be quite overwhelming and dissociative and so on. I'm thinking about people like me, who come out later in life, I was 36 when I started transitioning, and for me the moments of gender euphoria have been the moments where I go, this is fine, this is not just in your head, this is right. Not the moments of dysphoria. The moments of dysphoria just make you want to fuck up. In my own experience, and, talking to a wide variety of patients, it's been useful to focus on those moments, and it's also when you think about it, it's a strengths-based approach, where you're not

reporting something that is wrong with you, you are reporting something that feels right and feels like it should be celebrated.

It's very much like, when someone correctly gendered you, or when your mother used your chosen name, or after you started hormones, or when you had your surgery, those moments that people bring to therapy, because they want to celebrate them. These are moments of light; I want to talk about them. So, we talk about them, and I tend to label those moments as gender euphoria, in the moment and I position it as not gender dysphoria. It seems to be quite useful to patients to actually have that label.

Experiences in training – the dynamics in the room

The training I'm involved in for Gender Dynamix is run as weekend workshops. It has such mixed audiences, in terms of different professions, but also in terms of education level because there are community members or activists present in the training as well. On the one hand the power dynamics are quite visible, or tangible, almost like you can feel it or see it quite easily, but you have to be awake to negotiate that, between yourself and other people, and between the various subgroupings. I think my style of facilitation is sort of more, putting the ball in your court. It's not only the power between the people in the room, but also the power of the construct of gender, on each participant. You are sitting with not only the dynamics in the room between the participants, but you're also sitting with the dynamics, with their own dynamics and their own stuff around gender.

As a psychologist I am very aware that if I push too hard at some points, I might lose this person because I realise that there is a personal discomfort there. If you think of the discursive construction of gender, the discourse around gender is very binary, and very prescriptive, and very clinical, and those discourses have power, those discourses shape the way we think about gender. People bring so much history into the room with them when you do training around gender-affirming healthcare.

I realise we cannot change everyone's minds in one or two training sessions or interventions or whatever. But if they can understand the knowledge at least, understand the science and the evidence, the attitudinal changes will come. I think maybe this is the natural progression, that you start with knowledge and that translates eventually into attitudinal shifts. That is sort of the thing that helps me sleep at night.

5.2.4 Analysis of research story 2

This story, told in the first person, follows E's inner journey, which is intertwined with his professional journey. As with research story 1, the negative experience of accessing healthcare is contrasted with what it can be – the GP, the care that E provided and the positive experience of his patients.

The story starts where E is a student, and critical of the silences in the psychology masters' curriculum. He uses the term 'queerness' as a broad term to refer to what falls outside a cis-heteronormative approach. Even though a critical approach was taught, the course did not include content on sexual and gender diversity. When E questioned "how people were spoken about", he may have been critical of it not being an affirming approach to patients. Although not explicitly stated, he appears to have had a clear understanding that an affirming approach to queer patients should be part of a psychologist's training.

As a young psychologist he often saw TGD patients, even before coming out as transgender himself, and describes learning as he went along. From his student experiences questioning the lack of curriculum content about 'queerness', he already had the openness to seeing TGD patients, and a desire to provide care that was affirming. He learnt from colleagues as well as a journal club that was formed to discuss gender diversity. The process of learning to be affirming is ongoing, and humility is required to be honest about not knowing and about making mistakes.

His own transition had a big impact on his PIF journey. He had to make the shift from seeing being trans as pathology or illness to an identity. In his own personal journey, he describes his initial attempts at facing being transgender as "not helpful" until he realised that there is no "fixing" possible. This shift impacted on his approach to patients, to really just giving them space to be themselves. The context for this is that for many years, healthcare was practiced in a way where TGD patients had to fit into a certain construct of diagnostic criteria, requiring a formal "assessment" as described earlier in Chapter 2. His own way of practising is very different from that, that he does not expect patients to prove to him that they are trans, and this is informed by his own experience.

The first narrative of seeking healthcare, of not being seen as a human being, but as an exam question, is a stark example of non-affirmation. The ignorance of the registrar, consultant, and student about GAHC stands out. This is in the context where GAHC does not form part of the formal curriculum for medical students.

The power dynamics in the consultation is very unequal. The plastic surgery consultant holds the power to decide who will be booked for surgery. She does not like being challenged by a patient about her knowledge of GAHC, and it is possible that this influenced her decision-making.

As with the previous research story, E is acutely aware of his privilege. He is an educated person who can exercise his right as a patient to question the doctor, and as someone who can save up for private healthcare. There is a recognition that TGD people are often in a vulnerable position in a consultation due to the power imbalance. Patient empowerment to be able to stand up for their rights and to be able to educate health professionals about GAHC is required.

There is a counter-narrative of affirming care by the GP and the surgeon who eventually did his surgery. Even though the GP was not experienced in GAHC at the time, E had an affirming experience. She was open to listening and learning. In the PIF journey of this GP towards being gender affirming, she brought her feminist awareness of people marginalised by patriarchy, which created openness for her to learn. The power relationship between the doctor and the patient was very different in this consultation. The GP was not offended by the patient educating her about GAHC but rather welcomed it. This contrasts with the previous narrative of the plastic surgeon. The PIF of the GP is an ongoing process, with lessons learnt from patients such as not making assumptions.

E describes that coming out to his patients as trans, led to greater authenticity in the consultation. As with the first story, the personal experience of transitioning led to a deep understanding of the experiences of TGD patients. This includes knowing how anxious they are initially before they know that they will be affirmed without having to perform in a specific way. He recognises that debriefing about past trauma with

negative experiences of accessing care often forms part of being affirming in a consultation. With his personal experience, he is able to understand that aspect deeply.

E made a shift to use a strength-based approach and focus more on what he terms “gender euphoria”, than gender dysphoria. To focus on moments where one’s gender identity feels right has been useful for him in his individual journey as well as in consultations. This aligns with a depathologising perspective.

In the last chapter of the story, about training experiences, he reflects about the power of the gender construct within individual participants as well as the power between people in the room. There is a recognition that people are at very different places in terms of their journey of PIF, with some still dealing with internal processes around gender. Being a participant in training can be a powerful experience of socialisation to unlearn unhelpful approaches. It stands out here as well that it is an individual journey over time that does not happen overnight. E accepts that as trainers we can only cause small shifts in people and is comfortable with that.

What stands out in this story is that for a consultation to be affirming, a shift in the power relationship is required. The health professional has to recognise the patient experience as valid and respect the patient knowledge about their identity. Authenticity and humility are key.

Drawing this journey, there were already gender-affirming consultations before coming out. The encounter with the plastic surgeon had a power differential and she did not see the human. The story continues to E teaching others to really see their patients as humans first. The use of drawings was an attempt to make sense of a complex process. This is a representation that may make the process appear more linear than it is.

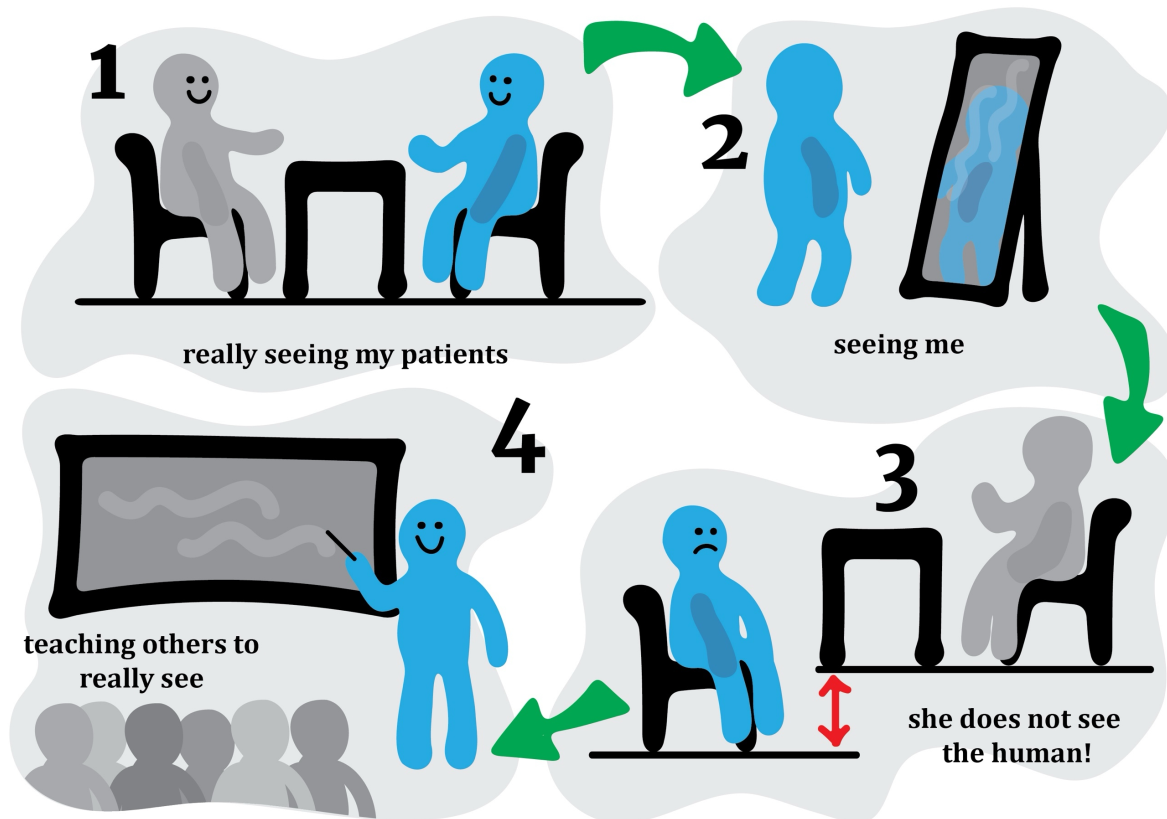


Figure 8: Drawing of research story 2.
Source: Graphic design by Suki Lock of Jagged Daisy**.**

I will complement the inductive approach in the analysis of this story with a deductive approach, looking through the lens of PIF, considering both the individual and socio-contextual level (Jarvis-Selinger et al., 2012). This will demonstrate the many different sources of learning in the story.

E experienced tension between the innate ring (own values) and the societal ring in his interaction with the first plastic surgeon. He had a clear understanding of what was right and experienced a disregard for his view. This is an example of epistemic injustice (Fricker, 2007; Thomas et al., 2020) where a health professional does not take the patient narrative seriously. His experience with his GP was very different and forms a counter-narrative as discussed earlier.

The friendship with another TGD person would fall into the relation ring of the RToP. This was a source of learning about GAHC for E, as they learnt together by doing research online and asking other TGD people about dosing and blood tests.

E describes a learning curve with seeing TGD patients in his practice. In terms of the RToP, there is alignment between the innate and societal rings; his interaction with patients is described as positive. When he came out to patients, he experienced it as bringing greater authenticity to the consultation. Patients found it useful when he used a strengths-based approach of looking for gender euphoria. This concept will be discussed in more detail in 5.2.2.7 (Discussion: affirming in every space).

His interaction with workshop participants would also fall in the societal ring. In this context he is in a position of power. He is very aware of his power and the impact that he can have as a trainer. There is alignment between the innate and societal ring, with his approach to facilitation in line with his values.

The socio-contextual approach views PIF as taking place in a social context (Mount et al., 2022). In this research story, there was evidence of a community of practice (Lave & Wenger, 1991) in the description of the journal club discussing gender diversity. It created a space for sharing information, e.g., regarding GAHC guidelines.

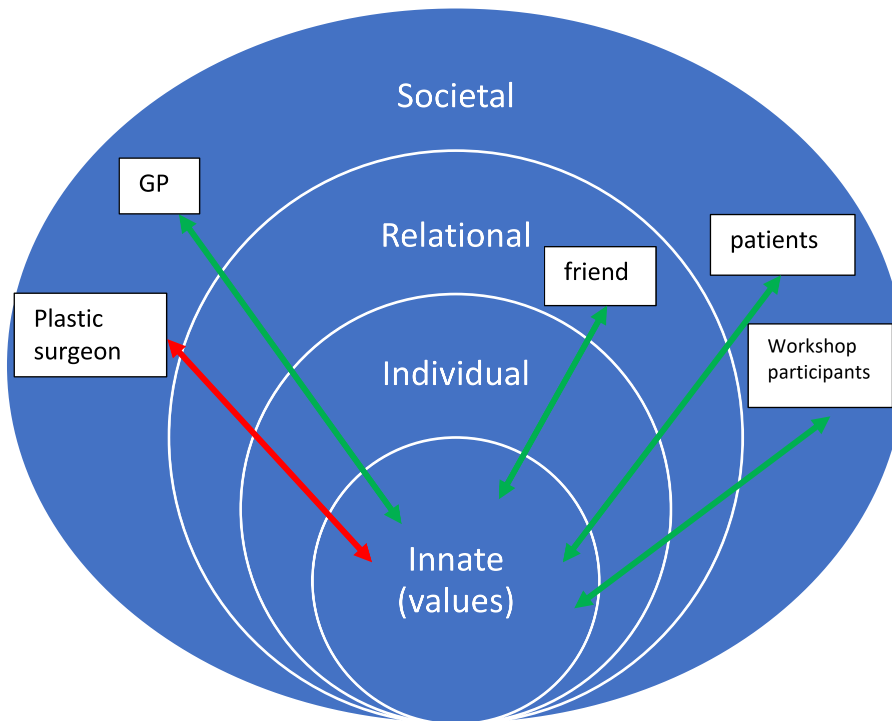


Figure 9: Tensions and alignment between rings in the Ring Theory of Personhood for story 2.

Red arrows indicate tension and green arrows alignment.

Source: author added to the original graphic by (Radha Krishna & Alsuwaigh, 2015).

5.2.5 Research story 3: "An activist friend opened my eyes."

Introduction

This research story starts with D's experiences at medical school, including her experience as a patient. It then continues to how she got involved in GAHC through an activist friend, and her experiences in practice. D is a cisgender medical practitioner who has a network of medical practices that provide friendly and affordable health services inclusive of a specific focus on the healthcare needs of LGBTQIA+ communities. She is familiar with these communities as she identifies as a lesbian woman. The context of the story is a large city in South Africa, where the need for affirming healthcare is much bigger than the available services.

Experiences as a student: arguing with a doctor about me being sure who I sleep with!

Being gender-affirming is not something that is really discussed, you know, in medical schools. I went through medical school, and this never came up! But now we expect the same young doctors to work in the public hospitals and in the township practices, where they would be exposed to trans individuals for instance, and they are not trained. It seems the medical schools have not recognised that there is a need that the medical professionals who are coming out, are gender-affirming.

The first time I thought of the field was when I was still a student and I had to consult medical services as a lesbian woman. Some of the questions I was getting from a practitioner, it got me imagining what other members of the LGBTI community are going through, when faced with providers of that same attitude. Okay, so I went to see a general practitioner, and I had lower abdominal pain. And then she started asking around sexual activity and if I used a condom, you know, so then I laughed and said there is no need for me to use a condom, you know, and she started telling me about all the dangers I am putting myself in by not using a condom, you know, like STD’s and HIV and things like that, and I explained to her that my sexual activities are with women, with people of the same sex. Then she wanted to do a pregnancy test, and I was like, well, there is no need, like as I said, I am lesbian, you know and she said no but we just need to be sure, so we had a whole argument about me being sure who I sleep with!

An activist friend opened my eyes.

I started learning about gender-affirming care when friends, who are activists, directed me to the Gender Dynamix site, and advised me to be in contact. The first person was an activist with Iranti. He was one of the people coming to my practice and started saying to me, you should look into providing this type of service and these are the type of people you need to contact. I realised at that point that he was coming to me for assistance on something that I did not have, and I didn’t know there were resources, because it’s something we did not do in medical school. I really didn’t think there were resources out there, and he opened my eyes to it. He was already on hormones, so he was coming to me just for continuation of care. But then telling me there are a lot more people who would want to be initiated on hormones, so I need to equip myself to be able to manage them.

I then reached out. I asked my activist friend to do the initial introduction, you know to help me get connected in the right way. I was open and frank and said, this is me, these are my limitations, and I would like to get the information on how to provide this service. The organisation was very responsive and immediately sent me information to read, and then I was also invited to a conference, where I interacted with other practitioners in this space, and just got to learn more. I continued doing my research on what the practices are in other countries, you know. I learnt a lot more from the patients that would come in, you know, some who had already been on treatment, and they would tell me their experiences. What I found most difficult was the trans women care, so that is where I engaged a lot with organisations, especially because the treatment was more costly than the trans men, just to find affordable options, but still maintain the clinical excellence.

Stories from practice: patients really feel that we are part of their process.
Gender-affirming means firstly recognising and respecting the patient, as they present to you, in the way they want to present, and also when they realise, they are not presenting physically, as they are mentally, you know they would need your assistance in that regard.

In my practice, it starts from the interview stage. You know, we make sure we have practitioners with the right thinking in this space, because everyone will come with the same level of qualifications based on the advert, but the attitudes are something else. So that’s why we make sure when we interview, we ask those direct questions, to say, in this type of situation, how would you manage this patient? We give patient scenarios, you know, and it’s not just trans healthcare, it’s LGBTI health in its entirely; an adolescent who is pregnant requiring a termination, all those scenarios that we feel will show us the type of thinking that you have. We can send you for the training, to be able to do trans healthcare, but the attitude I don’t think is something you can easily teach.

We do sensitisation training in the practice, from the receptionists to the clinicians. We also have a feedback mechanism where we use social networks, for patient feedback, and it has been positive. Even our trans patients who come to our practices have their preferences already, that they want to be seen by a specific doctor. These are doctors who are cis heterosexual people, but they have been so well trained, that, I mean I remember we had one trans woman who had been on hormones, and managed by one of our doctors, who is a cis heterosexual man, you

know. When the patient started developing boobs, she got so excited and just came to the practice to show him, to say, look at the progress we are making, and patients really feel that we are part of their process. Being a gender-affirming practitioner, yes, I think it is very fulfilling.

Reflecting on my learning

I can't image a stage in my life where I was not gender-affirming, you know, even with the limited knowledge of what the transition process would look like, I've never had issues where I felt I needed to grow into being gender-affirming. I believe in my general behaviour in society, even within the profession, I have always been gender-affirming, because I have always been exposed to people of different genders.

I did not think of being trans as a pathology at any point. I knew it was an identity but also knew there was not enough clinical literature to support my quest to ensure that people are managed properly. I knew that part of the process was to give hormones to affirm but also knew that this came with risks I needed to be aware of as a practitioner.

I think for me personally I really want to keep on learning, especially for my community where I feel like our practitioners do not care for this. I want to influence politics, I want to influence learning in medical school, I want to be a positive influence on the other practitioners in my area.

I believe that medical schools should do better, creating practitioners who put patients at the centre.

The guys when they are undergraduate, going to internship, they will be the first point of contact for many of the patients and it is shocking that they will not be ready and that their attitudes are not addressed, you know sometimes even if you do not have the clinical knowledge, just having the right attitude and the willingness to learn, makes a big difference.

Firstly, something as easy as pronouns. You know if that intern or community service doctor is not trained to respect that there could be different pronouns, and just insist on using a pronoun that the patient is not comfortable with, that will become a big barrier, that will make the patient not to trust you. Because sometimes with the clinical knowledge, as doctors we are trained to refer to specialists if we are not comfortable treating a certain condition, but you know our attitude is never, that is not

a real problem because you don't have the expertise for it. So sometimes not having the clinical knowledge, just knowing there are people that you could refer to makes a big difference in patient management.

I would say medical school created demi-gods, where you go out believing that you know what is best for the patient, you are going to tell the patient to do this, or this will happen to them, take this three times a day or you will die, or something like that.

Now with gender-affirming health, it forces you to be a different practitioner, even to your other patients, you know to say, the patient is in control, or is in charge of their own healthcare and wellbeing, you are there to listen, understand and then offer you know, different options, treatment options or just options on how the patient can be better or be well. You know, it involves you being in consultation with the patient and respecting them as a person that is a decision-maker, you know in their health and wellbeing.

My thinking is really around medical schools doing better. Medical schools should not make it one of the electives, you know, it should be part of compulsory training, you know the same way, you would teach sexual and reproductive health, in its entirety. I think medical schools should really put emphasis on sensitisation and creating practitioners who put patients at the centre of their healthcare, because I think when that happens, it will influence everything else positively.

5.2.6 Analysis of research story 3

This is a very different journey compared to the first two research stories. D says that she has always known people of different genders, and always had an affirming attitude. The main learning for her was the clinical aspect of how to provide hormones in a safe way.

She is very outspoken about the gap in the training of doctors, that young doctors are not prepared for affirming practice. She had a first-hand experience of an ignorant doctor, who understood very little about diversity in sexual orientation. This made her think about the need for training on attitudes.

For D, an affirming and non-judgmental attitude is important towards all patients. This is clear from her description of how they select doctors for the practice – in the interviews there are specific questions to gauge the doctor's thinking regarding "LGBTI health in its entirely", as well as aspects such as a teenager requesting a termination.

When D reflects on essential knowledge that should be part of medical training, she specifically mentions pronouns. She points out what impact it can have on the doctor-patient relationship if a doctor does not respect the patient's pronouns, "that will make the patient not to trust you." She does not expect all doctors to have the clinical knowledge, but to have the attitude that the healthcare needs of trans people are real. She wants doctors to be able to be patient centred and really see the person.

The description of GAHC as knowing the patient is in control and the doctor there to listen and offer options reflects a deep understanding of a different power dynamic in an affirming consultation. She makes the link that this approach applies to other patients too and contrasts it with her experience of medical school that produced doctors who think they know what is best for the patient. She has the courage to practice differently from the way she was trained, with recognition of the patient as a decision-maker about their own healthcare.

An activist friend who came to her practice for continuation of his hormone treatment opened her eyes to the need to learn about GAHC, and that there are resources available in South Africa. This led to the next step in her journey. Although she already had an affirming attitude, this started a learning process about gender-affirming practice, about how to provide care. In addition to the information and training in GAHC she received from the NPO Gender DynamiX, she learnt from her patients' experiences. The fact that patients were willing to share their experiences, and that they feel the doctors are part of their process, is testimony to her affirming approach. A specific area for her to learn about was affordable hormonal treatment for trans women, which is a very practical aspect. She cared enough for her patients to try and find the most affordable options.

What does this story bring that is new? The PIF journey is different for each person. For D, the affirming aspect of her professional identity was there from the beginning. She sees it as broader than just gender affirmation, and that it is a different approach to all patients, with a different power dynamic in the consultation when the doctor recognises the patient as a decision-maker. The clinical aspect of providing hormone treatment was her main area of growth.

Drawing this story, the GP consultation had an unequal power dynamic, the GP could not see D as who she is. A significant moment in her journey was the activist friend encouraging her to learn. She had to gain the knowledge about GAHC, following which she could provide GAHC. The use of drawings was an attempt to make sense of a complex process. This is a representation that may make the process appear more linear than it is.

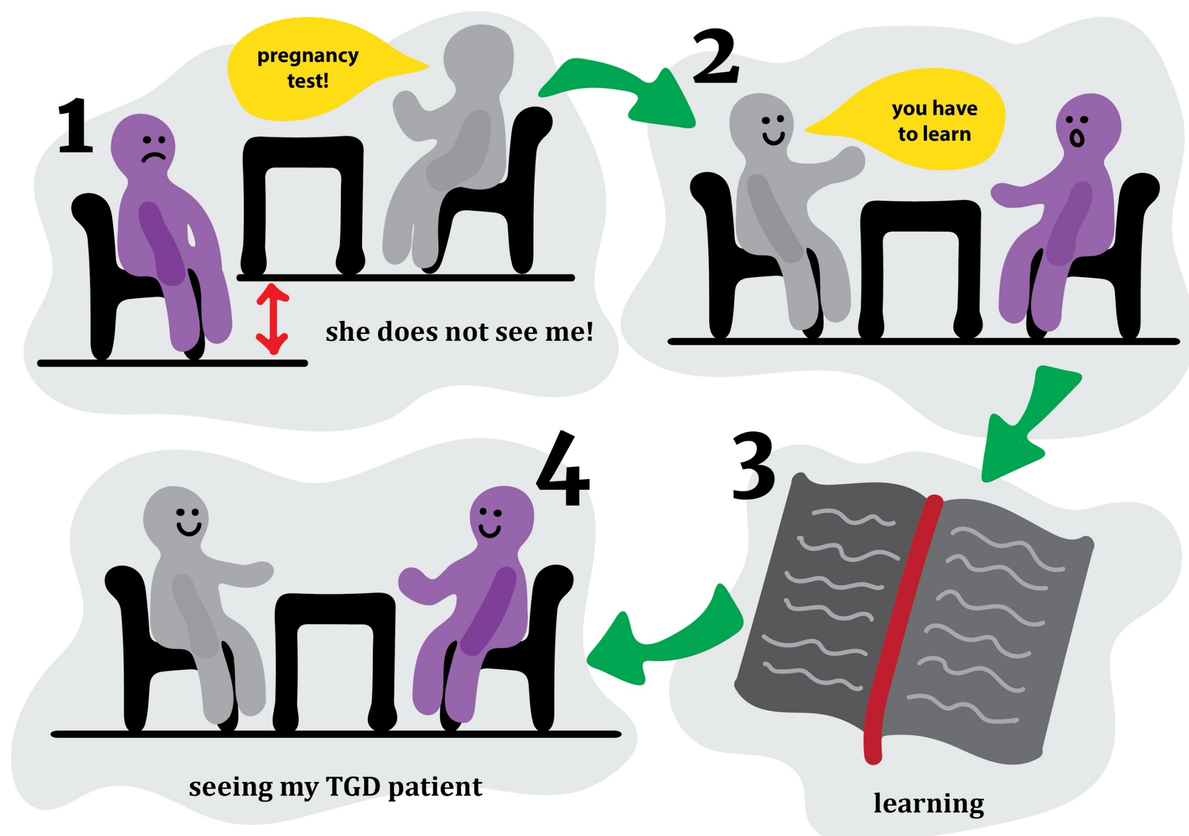


Figure 10 Drawing of research story 3.

Source: Graphic design by Suki Lock of Jagged Daisy**.**

Augmenting the inductive with the deductive approach of looking through the lens of PIF in this third story, different relationships impacting on D's learning are foregrounded. As with previous stories, the negative interaction in a consultation triggered learning. The activist friend played a significant role, as well as the NPO and learning from patients.

Regarding a community of practice, she created it in her own practice as D could not find one. She is selective with who gets appointed and chooses practitioners who are open to learning more and she organises sensitisation training in the practice. Practitioners learn from their patients and then share their experiences.

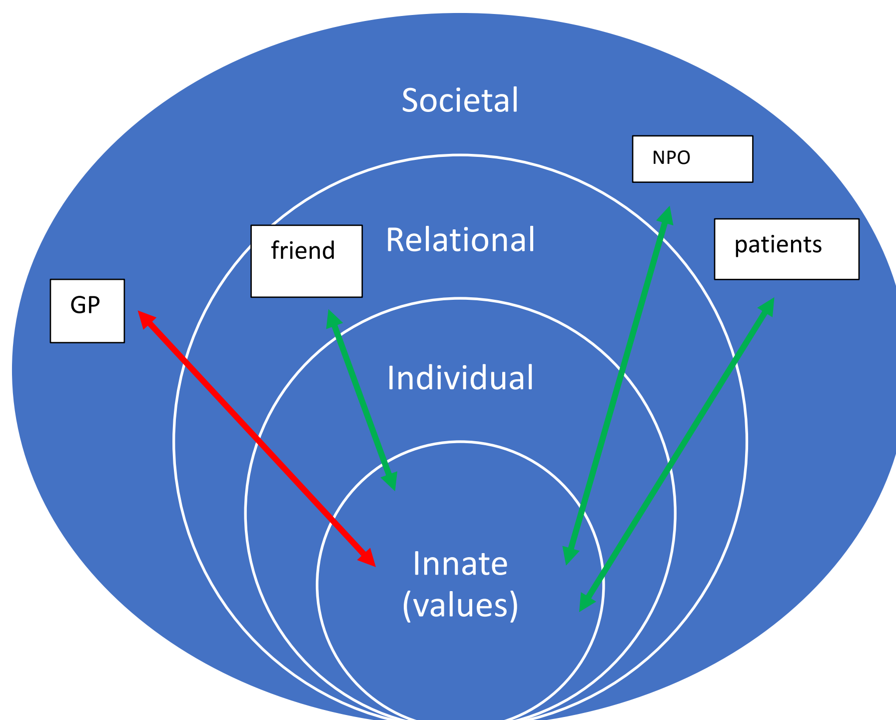


Figure 11: Tensions and alignment between rings in the Ring Theory of Personhood for research story 3.

Red arrows indicate tension and green arrows alignment.

Source: author added to the original graphic by (Radha Krishna & Alsuwaigh, 2015).

5.3 Analysis of narratives: themes relevant to objective 1

Following the three research stories, I will now present the themes from the analysis of narratives, that are relevant to objective 1. The data that was analysed for this include the interviews with the six practitioners as well as the eleven students.

The main themes in this chapter are: "Becoming gender-affirming is a journey of ongoing learning; "Affirming in every space"; "Learning from lived experiences" and "Learning online".

5.3.1 Becoming gender-affirming is a journey of ongoing learning

Participants (gender-affirming medical practitioners and psychologists) described the process of becoming gender-affirming as not a destination, but rather a journey, an ongoing process. In the three research stories this was evident as well, that there was a process of learning and becoming. Every individual would have their own unique journey, with different ways of becoming gender-affirming.

In research story 1, T describes an inner journey of confronting internalised transphobia. For E in research story 2, making the shift from seeing being trans as pathology to seeing it as identity, was a significant part of the process.

K sees the process of becoming a gender-affirming practitioner as ongoing: "I think it is a non-stop process, so it keeps on evolving". And: "For me it is much more a gradual becoming more skilled as a therapist within the context and that is a continuous development even now" (K, transgender practitioner).

N describes an ongoing process of learning, and compares it to ongoing learning for other conditions:

> Yes, and also learn who to refer to or ask, because even us, I still ask a lot…, you know, I'll go to the guidelines, I'll go to the international guidelines, you know, I'll sit and read, so every day is a learning curve, even for hypertension, I still go for updates, so, it's the same thing (N, cisgender practitioner).

In the second interview, when I asked about the process of becoming, D threw me a curve ball, and said she felt she always had an affirming attitude, as seen in research story 3. This is different from the other participants, who talk about a journey of becoming. For D, it was a journey of learning more, to get the information to provide the service, but she saw that as separate from the attitudinal aspect.

It is not an easy journey for everyone. SM found it initially quite stressful when she was learning about GAHC: “So, it was like driving a car without a seatbelt. It was both very exciting and very nerve-racking” (SM, cisgender practitioner).

If, as a researcher writing this chapter, I reflect on my own journey of becoming gender affirming, it is certainly ongoing. I keep on learning as the field evolves and understanding about gender diversity expands. Getting my head around the concept of depathologisation, of seeing the human and not a pathology has been part of the learning.

In the PIF literature, it is clearly articulated that identity is not static and PIF is an ongoing process (Cruess et al., 2015). It has been described as a complex, non-linear and fluid process (Sarraf-Yazdi et al., 2021). Holden et al. (2012) stated that “Professional identity is constructed from a multitude of experiences processed through the unique filter of each individual. Each experience and the individual’s assessment of the experience may be seen as a tiny contribution which shapes the whole” (Holden et al., 2012, p. 249). This process does not end when a student graduates as a doctor but continues to evolve throughout an individual’s lifetime in a dynamic fashion (Orsmond et al., 2022). This resonates with the description by participants in this study of a multitude of experiences contributing to their PIF.

McGeorge et al. (2021) write about the process of becoming an affirming family therapist, and says like E did, that it is not about a place of arrival, it is a life-long journey (McGeorge et al., 2021). They describe a three-step critical exploration model for becoming an affirmative therapist, where a therapist reflects on “(1) binary normative assumptions, (2) cisgender privilege and binary advantage, and (3) cisgender identity development” (McGeorge et al., 2021, p.790). Of interest is their differentiation between the journeys of cisgender and TGD therapists, with the

second and third steps mostly relevant to cisgender therapists as most TGD clinicians have extensively reflected on their gender identity (McGeorge et al., 2021). From this study, the journey of the cisgender and transgender participants have been different, with the transgender participants learning from their personal journeys, while the cisgender participants learnt from friends and patients. This will be further explored in 5.2.3 (Learning about GAHC from lived experiences).

While the focus of the PIF literature is mostly on the process during training and beyond, Mokhachane et al. (2023) emphasise the fact that the PIF of medical students already start before they enter medical training (Mokhachane, George, et al., 2023). This perspective helps to understand what D said, that she always had an affirming attitude. She gained more knowledge about GAHC later in her career, but the foundation of her professional identity as affirming was already established. In research story 1 we see that T's liberal political views was an aspect of her identity that she brought with her to medical school.

Looking at the journey towards becoming a GA practitioner, through the lens of PIF, as an ongoing process of learning and becoming over time, has implications for thinking about how to help medical students to become affirming practitioners. It is not something that can happen overnight after a once-off lecture, rather a process over time. This will be discussed in Chapter 6 in theme 6.4.8 Timing in curriculum and integration.

This section discussed the process of becoming gender-affirming as a journey of ongoing learning. The next theme will shed light on the understanding of what gender-affirming means. What is this ideal that people are journeying towards?

5.3.2 Affirming in every space

It is important to explore how gender-affirming is understood as a concept by the practitioners and students in order to describe the PIF of a gender-affirming practitioner.

Gender-affirming is illuminated from different angles in the interviews. It is described as an attitude to all patients. In the context of a consultation, there is differentiation

between a patient presenting specifically for GAHC, and a patient presenting for other reasons, with a strong argument that a gender-affirming approach is relevant in all contexts. In addition, participants described it in terms of the impact that it has on patients ("very tangible relief") and that patients who are affirmed, are empowered to participate in their healthcare. Becoming and being a gender-affirming practitioner includes the role of educating others about GAHC. I will discuss the different aspects below.

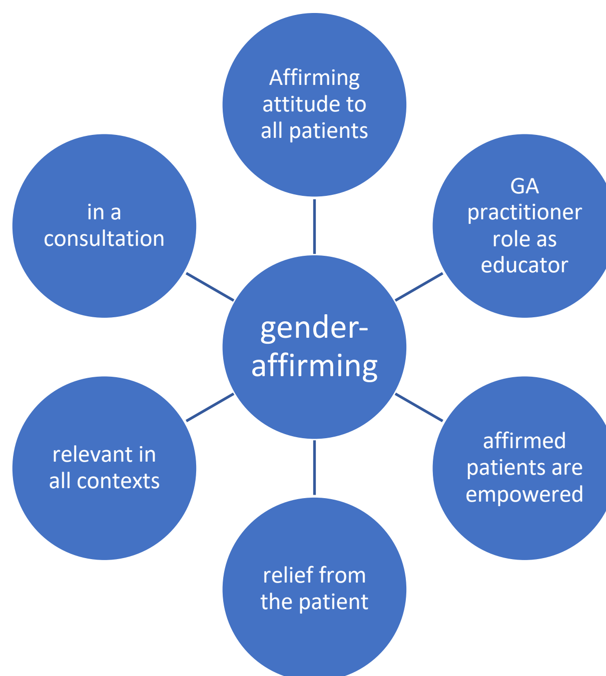


Figure 12: Affirming in every space. Source: created by author.

5.3.2.1 Affirming attitude to all patients

Participants describe being affirming as a broader concept than simply when dealing with TGD patients, as an approach to any patient that they see. For D, it is a different approach that is relevant to all patients, as seen in research story 3.

K describes being affirming as a lifestyle, a way of being, and always part of his therapeutic approach, not just for TGD people. "It is not about something that you just perform … you live an affirming lifestyle, and that is in all contexts. For me from the onset, in all practice, when a person walks in, you already affirm them for who they are, being it sexuality, being it gender, being it identity, being it how they see themselves, and you start off from there" (K, transgender practitioner).

SM describes affirming as wider than GAHC:

> So, we are affirming all sort of things in medicine, and gender is one of them, so gender-affirming means affirming that people are the gender which they know themselves to be, even if it's not the gender that other people would regard them as (SM, cisgender practitioner).

One of the students emphasised that it is for every patient: "It's about creating a space that is open to any identity, with no assumptions and no expectations, and creating a healthcare situation where every patient feels comfortable" (TB, cisgender student).

In the research journal, this theme emerged as well: "A respectful doctor-patient relationship, for the doctor to really see the human being. And that is wider than just gender-affirming health care - it is for all health encounters".

If I think of the practitioners that I interviewed, it is an affirming lifestyle and their approach to all patients, of seeing the human first and not disease or pathology. It is an openness to diversity, to meeting the person where they are at and not expecting them to fit into a certain box; to take their story seriously. As health professionals we all come from a certain cultural background and will come across patients that are very different from us. With an affirming attitude, we do not have to be scared of difference, but can rather embrace it and learn from our patients.

K commented on embracing diversity:

> I am against the pathologisation of a gender identity that is just part of the natural aspect of human diversity. There are so many diversity aspects in humankind - being it race, neurological functioning, eye colour and so more - why should gender be pathologised? Why can't it just be part of the gender spectrum or universe? Diversity should be embraced as it makes life wonderful and fascinating (K, transgender practitioner).

From a critical perspective, it is also disrupting the gender binary, by accepting the patient's gender identity as they present it to the health professional, without expecting them to fit into a binary understanding of gender.

Participants see being gender-affirming as an aspect of an affirming approach to all patients. The next section looks at how this approach manifests in a consultation.

5.3.2.2 Gender-affirming in a consultation

Participants reflected on the meaning of being gender-affirming in a consultation, that it is about respect and listening. The research stories include powerful descriptions of consultations, where the patient has the freedom to be themselves without judgment.

> I think gender-affirming is anything that allows you to experience gender euphoria, to feel that, you know, this is my body, this is mine, this is who I am, and I'm able to live in a way that feels authentic, that doesn't feel like conflicting. We live in a society where gender ideals and norms are always thrown onto people, and you know being assigned a gender at birth, so that's always like, thrown onto you. When we affirm people's gender, it's almost to say like, no, you don't have to do this, you know what is best for you, and what that looks like, and these are the ways in which we can help you come into that (B, cisgender student).

This reflection about what gender-affirming means, says a lot about power in a consultation. By saying, "you do not have to do this, you know what is best for you", the health professional gives power away and recognises the patient as someone with agency.

D emphasised recognising and respecting the patient as they choose to present to you. "You know, saying you are non-judgmental, you listen to the person's needs and requirements, and you don't have any pre-conceived ideas about what the person wants" (D, cisgender practitioner).

This links to what L said about avoiding assumptions:

> Being a gender-affirming healthcare practitioner for me is firstly not assuming everybody is cis, so not thinking cis normatively, and taking the cue from particularly non-cis patients who approach you, with whatever their needs are, and facilitating those needs as best as you can (L, cisgender student).

The listening aspect was emphasised by AA as well:

> I think it's really about listening to the patient, and hearing what they expect from the treatment, setting a goal together, and just basic empathy and respect for the person, even if you don't understand what they identify as, or maybe their experiences, just being open-minded to it, willing to do research, but Ja, listening to the person (AA, transgender student).

This is a difficult aspect, that many health professionals may not understand their TGD patients, especially if they have not been trained in GAHC. If we are able to be open-minded and willing to do research as AA says, it is possible to learn. The PIF of a gender-affirming practitioner is a process, and an affirming attitude can precede having the knowledge and understanding. Listening is valuable both for the patient to feel valued, and for the practitioner to learn.

T contends that the attitudinal aspect is more important than knowledge about hormones, and understanding the challenges that TGD people face. She refers to barriers such as, "will I be treated with respect? Will I be treated with dignity? Will I be dead named? Will the correct pronouns be used?" (T, transgender practitioner).

Being affirming includes facilitating access to treatment, as opposed to a gatekeeping approach:

> Will I be asked like a bunch of irrelevant questions and feel like I need to prove myself in order to get access to hormones? I mean we use hormone therapy all the time for all kinds of people, without restriction, but it's so much more heavily policed when it comes to trans patients. I think it's like empowering people to understand the challenges that those patients face, and dismantling those barriers, making the service more accessible. It's that safety much more than the clinical competence that really dictates what kind of an experience it will be. I mean you can go to a widely respected endocrinologist, who might have a really good handle on the physiology of sex hormones, but if she treats you like dirt, it's going to be a bad experience, and

> you'd much rather go to the doctor who's, like 'alright, I actually have to look this up', but who respects your identity as an individual (T, transgender practitioner).

T speaks from personal experience of care that is not affirming, where the human is not seen, and a certain performance is expected to be able to access hormones, as is evident from research story 1. The comment about hormones that are used for different indications, but for GAHC it is more difficult to access, comes from a perspective that access to gender-affirming hormones should be easy. The difference is that gender-affirming hormones could result in irreversible body changes, which would not happen for a cisgender person taking hormones aligned to their sex assigned at birth. The thorough informed consent process for accessing gender-affirming hormones is perceived as "policing" by some activists. My view is that access should be easy, but that the patient should understand the potential impact of hormones in order to make an informed decision.

E points out that it is about more than hormones and surgery:

> I want to look at quality of life stuff, I think this is an important aspect of gender-affirming care, because I think we run the risk of thinking of it just as access to hormones, and surgery, but actually we need to think about more. We need to think about relationship stuff, and sex stuff, and finding your body in this new space, that you occupy (E, transgender practitioner).

This is an important aspect of holistic or comprehensive care, that as health professionals we not only think about the biological aspects but consider the patient experience as their body changes, as well as recognising that patients exist in a context where they may have romantic and sexual relationships. An affirming attitude includes not shying away from those aspects of a patient's life.

CM sees it as a relational concept: "Being gender-affirming is an interplay between the doctor and the patient that enables the patient to more fully realise and express themselves, because the doctor is expressing themselves in a way that affirms that patient's own identity within themselves" (CM, cisgender student).

In a consultation, attitude is described as the most important aspect, that it is respectful, non-judgmental, accepting the patient's gender identity, creating a safe space. It includes listening and paying attention to the relational aspects of the consultation. It respects the patient's agency and autonomy and facilitates access to gender-affirming treatment. TGD patients do not only seek healthcare for gender-affirming treatment and the next section will explore this aspect.

5.3.2.3 Gender-affirming is relevant in all contexts

When TGD people present for other healthcare, this needs to be affirming too, as highlighted in the first research story where T says that TGD patients can present for different reasons, they can have accidents, chronic illnesses, or the common cold. She speaks about general healthcare needs of TGD people, in relation to which ward a TGD person will be admitted, how the nursing staff would treat them, and where they would go for screening tests, for example a trans man who needs cervical screening. "Being an affirming practitioner is about being affirming in every space and every sphere and recognizing that the needs extend beyond those that are specifically gender related" (T, transgender practitioner).

A student who identifies as transgender, said

> I sometimes think, we are only going to engage with trans healthcare if people are coming for transgender healthcare, endocrine, HRT healthcare, as if trans people are not represented everywhere, like if I have pneumonia I am still going to go to the clinic, and I'm not going because I am trans, I'm going because I have a pneumonia [laughs] (DL, transgender student).

Another student describes it as creating a safe environment:

> For me, it's about the culture of medicine. So, when you see a patient for a reason unrelated to gender-affirming care for example, but happens to be a trans woman, making sure you use the correct pronouns, making sure that the patient feels comfortable, and safe with you, identifying themselves as they do, and that you're not going to dismiss that or make it uncomfortable, not going to discriminate against them, even unknowingly. That for me is where it needs to start, creating a safe environment. And avoiding even the subconscious discrimination. Setting the tone for that, being clear that I as a doctor respect you, whatever your identity is (JL, cisgender student).

JL argues that all students need to learn about GAHC:

> …because for example if I am not interested in cardiology, I still need to rotate through there, I still need to learn it. So, I don't think it's fair to say, if you don't have a particular interest in LGBT healthcare, it's not something that you need to do. Because everyone is going to treat an LGBT patient at some point (JL, cisgender student).

This is for me a strong argument for all health professionals needing to learn about GAHC. Sexual and gender diversity is part of humanity, and our students need to be equipped to provide competent care, regardless of what a patient presents with.

In this section, the relevance of being gender-affirming in all contexts was discussed. Participants emphasised that TGD people will present for reasons unrelated to their gender identity, and that all practitioners need to be competent to create an environment where patients feel safe, affirmed, and respected. This includes using the person's name and pronouns correctly. The next section will describe the relief that patients can experience when an encounter is affirming.

5.3.2.4 Gender Affirmation in patient encounters: "The very tangible relief from the patient."

Narratives about patient encounters give a further glimpse of what a gender-affirming consultation could look like. Research stories 1 and 2 describe the immense relief from patients when they realise that they will not be judged and will be able to access care.

K describes being amazed by the relief of patients: "that feeling at the end of the session usually of the relief, of being seen for who they are and having a space where they can be free and validated and seen" (K, transgender practitioner).

SM sees it at a privilege to be part of patients' transitioning journeys. "It is seeing people when they are uncertain or looking wrong or whatever, and then seeing them changing, and hearing them talk about that. And saying, you know, "I just feel myself

now. My anxiety is much better, I’m feeling much freer, thank you so much” (SM, cisgender practitioner).

This relief is described in a context where many TGD patients have not been affirmed or have encountered gatekeeping where they are expected to perform in a certain way to be judged trans enough to access GAHC. In South Africa at the time of the interviews in 2019-2020, and the time described in the research stories of accessing care and seeing patients, which would be the years leading up to this time, many practitioners were still ignorant or followed outdated guidelines such as Standards of Care 6. It is also in the context of a society that is not universally accepting of diverse gender identities, which means that patients may have experienced judgment from family and friends even before accessing care.

It appears that a gender-affirming consultation results in a patient that is relieved because they are being affirmed for who they are. This can then result in patients who are empowered to participate in their healthcare, as discussed in the next section.

5.3.2.5 Affirmed patients are empowered to participate in their healthcare

K is a vocal advocate for a participatory approach, where trans patients are empowered. This entails a power shift compared to a traditional medical consultation, with patients taking responsibility for their healthcare and playing a role in educating health professionals about GAHC. This links to the earlier description of a gender-affirming approach as respecting the patient’s agency and autonomy.

> I very strongly believe in a participatory approach, where gender-affirming healthcare is not the responsibility of only the medical professional. So, by having patients that are educated in gender-affirming healthcare, you start developing a space where your trans patient has the ability to go into the healthcare system and train healthcare providers. So, I found that it is an amazing space, where in a certain sense, the power then lies within the trans and gender diverse patients when they access healthcare. This does not come from a rights-based model, but from an empowered model where patients have access to knowledge and then going there as ambassadors and living their own wisdoms and their own lived experience into the healthcare system. And we’ve seen amazing shifts happening within our context,

> where people would engage with doctors that have not been trained, have no knowledge, and in a certain way, in a gentle manner, train them about trans and gender diversity. It becomes a collaborative space of taking responsibility across the board. (K, transgender practitioner).

K's journal contains a rich description of his interaction with patients, as a trans person himself:

> And as I push, my patients push with me. They affirm me. They give me the energy. They find more and more valuable ways to push these walls. Not through violence but through kindness. We know we have the rights. Human rights are on our side. But to use it as a whip doesn't work where we live. We use compassion and care. We educate and answer the curious onlookers' questions. And we stay human. We are them as they are us. And through the process they start seeing we are human (K, transgender practitioner).

A participatory approach creates a change in the power dynamic in the consultation, which I think is a key component of an affirming approach. Power is shared between the practitioner and the patient, with the practitioner not having to be all-knowing but able to learn from a patient. This is different from how health professionals have traditionally been trained and has the potential to disrupt how we view healthcare.

I have observed that health professionals who are not very knowledgeable about GAHC can sometimes be alienated by a rights-based approach that can come across as almost militant, insisting on rights. Although one can understand the frustration from activists at the poor access to care, this approach has not been successful in increasing access to care. As K describes "using it as a whip doesn't work". It appears that a participatory approach, of patients working with their health care providers, educating them, can be more helpful for getting more health professionals to provide quality GAHC.

Affirmed patients can participate in their own healthcare as described by K when a participatory approach is followed by the practitioner and patients. K works in both the public and private sector and has experienced that a participatory approach can work in both settings. Another aspect of being a gender-affirming practitioner, is an

awareness of the need to educate others to understand about GAHC, which is the focus of the next section.

5.3.2.6 Gender-affirming practitioner role as educator

Of the six practitioners interviewed, five are actively involved in educating others about GAHC. In both research story 1 and 2, there is reflection on the role of educator. T emphasises the importance of education in forging gender-affirming professionals and describes medical students changing their perspectives following a training session with her. E reflects on the challenges of training in this field, as "people bring so much history into the room with them" regarding their own issues with gender. He describes how sensitive one has to be when training, to recognise the dynamics in the room.

N sees being an educator as an important aspect of her identity as a gender-affirming practitioner. She has the opportunity to be an advocate for LGBTI rights and recognises the power of explaining concepts in vernacular language (isiXhosa) so that people can understand.

> For me it means that I have the opportunity to go where people fear to go, and also where, I think if I was not a doctor, it would be difficult for me to go and still express my views. I've got a platform where people are shy to talk about stuff, but by the mere fact that I'm a doctor, I'm in a better position to express those views, and people will listen (N, cisgender practitioner).

As GAHC has not formed part of undergraduate training, there is a huge need to educate practitioners. Although doing training is hard work, what I have experienced is that there is a deep commitment to educating more health professionals. For professionals who are TGD themselves, this training comes at a personal cost. I have observed that it can be exhausting to train about concepts that are very close to the bone. Still, they persevere. I am aware that participants have travelled to neighbouring countries such as Botswana and Swaziland to provide training. Professionals who are gender-affirming understand the needs of TGD communities and are dedicated to the cause of improving access to GAHC. I count myself as one of them. When it is difficult to think that there will be another weekend away to

provide training, I keep in my mind's eye the people we do it for – TGD people who have a need to access GAHC to be able to live as their authentic selves.

In this section, educating others about GAHC was described as an important aspect of the identity of a GA practitioner. In the next section, the theme of affirming in every space, with its different components, will be discussed in the light of the literature.

5.3.2.7 Discussion: affirming in every space.

Gender affirmation has been described as the social process of being recognized or affirmed in one's gender identity, expression, and/or role (Reisner et al., 2016). It is multi-dimensional with at least four core constructs, namely:

> social (choice of name and pronoun, interpersonal and institutional acknowledgment, and recognition), psychological (internal felt sense of self-actualization, validation of gendered self, internalized transphobia), medical (pubertal blockers, hormones, surgery, other body modification), and legal (legal name change, legal change of gender marker designation) (Reisner et al., 2016, p. S236).

The South African Gender-affirming Healthcare Guideline (Tomson et al., 2021) describes an affirming approach as "centering on the individual's agency, autonomy and right to self-determination, as opposed to practices that pathologise and stigmatise transgender identity, imposing barriers to accessing healthcare services" (Tomson et al., 2021, p. 3).

The South African Psychology Society Guidelines for working with sexually and gender diverse people include a specific guideline on the necessity of an affirmative stance in all work and organisational contexts (McLachlan et al., 2019). It states that "An affirmative approach respectfully recognises diversity, including the expertise found in sexually and gender-diverse people's own lived experiences" (Psychological Society of South Africa, 2017, p. 49).

All these descriptions resonate with how participants articulated what gender-affirming meant for them, that it is about respect.

Rider et al. (2019) describe a trans-affirmative approach “that centers transgender voices and experiences, and asserts that being transgender is an identity, not a disorder” (Rider et al., 2019; p. 279). In the description of affirming consultations by participants, listening to the TGD person has been identified as key.

Two of the participants specifically referred to “gender euphoria”. In the second research story, it is described as “the moments where I go, this is fine, this is not just in your head, this is right” and by student B as “to feel that, you know, this is my body, this is mine, this is who I am, and I’m able to live in a way that feels authentic, that doesn’t feel like conflicting”.

Gender euphoria is a relatively recent term that originated in gender minority communities (Beischel et al., 2022). It is discussed in the literature review in section 2.7 Patient experiences and perspectives of GAHC. It has been described as enjoyment caused by the correspondence between the person’s gender identity and gendered features (Ashley & Ells, 2018) and “a joyful feeling of rightness in one’s gender/sex” (Beischel et al., 2021, p. 281). The descriptions by participants in this study align with how gender euphoria is articulated in the literature.

In the literature, there are far fewer descriptions of positive experiences of GAHC compared to negative experiences. A mixed methods online study in the USA (Baldwin et al., 2018), found that descriptions of positive interactions were characterized by use of language that demonstrated respect for diverse gender identities. A qualitative study in Australia identified respectful communication styles, welcoming spaces, as well as care and openness as positive attributes of GAHC services (Haire et al., 2021). Whereas these findings are from a patient perspective, it resonates with the descriptions by participants in this study, such as: “To me it means firstly recognising and respecting the patient, as they present to you…” (D, cisgender practitioner) and “just basic empathy and respect for the person…” (AA, transgender student).

Being gender-affirming is described by participants as creating a safe space. A Canadian study about implementation of primary care services for TGD individuals,

identifies implementing a safe space as a key responsibility of practitioners (Ziegler et al., 2019).

Little has been published about the experiences of TGD health professionals providing GAHC. An online survey of transgender and gender non-binary medical students and physicians found that in many cases individuals hid their identity due to fear of discrimination, substantiated by witnessing high levels of anti-TGD stigma and discrimination (Dimant et al., 2019). The study did not report on experiences of providing care (Dimant et al., 2019). A recent qualitative study of the experiences of transgender and gender expansive physicians (Westafer et al., 2022) reported emotional distress because of transphobia and dominance of a rigid binary gender paradigm. There was one quotation on the experience with a patient, reported for the theme of the importance of representation in medicine: "…just having that representation to have a trans or non-binary patient, point to me and be like, I can trust you, like, immediately, like you, you will see me you will respect me" (Westafer et al., 2022, p. 8). This resonates with the experience described by T in the first research story, that she could "signal to a patient that you are safe now".

What my study adds is a rich description of what gender-affirming means from the perspective of practitioners and students, as well as experiences of TGD practitioners providing GAHC.

In summary, theme 2 looked at gender-affirming from different angles. It is described as an attitude to all patients and is an approach that is relevant in all contexts. Gender affirmation is described in terms of the impact that it has on patients ("very tangible relief") and that patients who are affirmed, are empowered to participate in their healthcare. The next theme will explore how participants learnt from lived experiences.

5.3.3 Learning about GAHC from lived experiences

Significant learning about GAHC came from lived experiences – for some participants their own experience and for some in their social circles through the lived experience of partners or friends. Some learnt from patients, while most of the students mentioned student societies as an important space to learn from others.

"Lived experience" is a term used to describe experiences that have an interpretation of significance for a person (Frechette et al., 2020). Research stories 1 and 2 describe learning from their own lived experience as trans individuals, and from their patients.

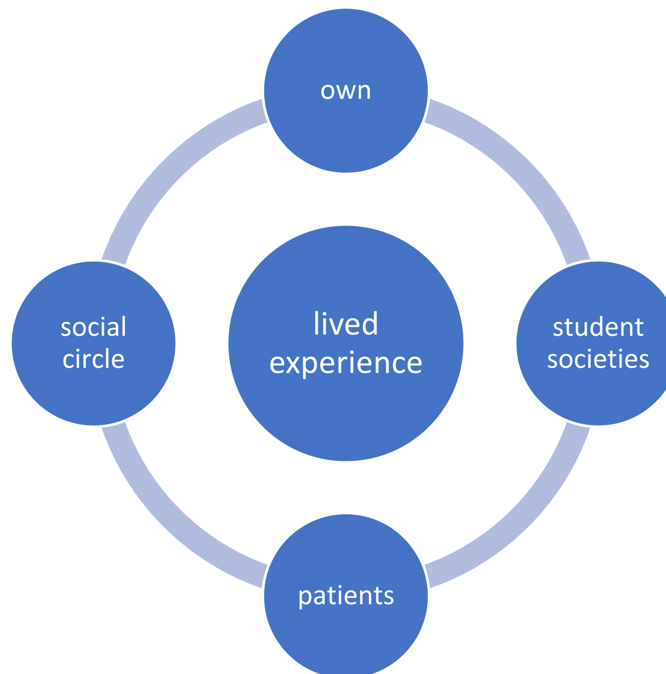


Figure 13: Learning from lived experiences. Source: created by author.

5.3.3.1 Sub-theme: Own lived experience

Three of the six practitioners interviewed identify as transgender. Of the nine students interviewed, two identify as transgender and one as non-binary. They describe learning from their own experience, as they explored their own gender identity, and as they accessed GAHC. Students who are not trans identified also described negative experiences seeking healthcare, that contributed to reflection on what affirming practice is.

"I think my lived experience plays a big part in that, being trans-identified myself" (T, transgender practitioner).

For K it was a gradual process of discovering his own gender identity. He initially did not understand his own discomfort about TGD people, until he realised that they reflect an aspect of himself:

> So, it was over years and then through that whole process also querying my own gender and then realizing that I fall very strongly under the trans umbrella, has also put a whole other facet into the whole space… For me much more a longer period of becoming involved in the community and then finding myself in the community, so for me the shift happened with meeting people that were presenting and living socially, as trans people. And feeling very uncomfortable, not understanding, realising now that I was looking at a reflection of myself that at that stage I could not embrace (K, transgender practitioner).

This "looking at a reflection of myself" is a powerful image. For a TGD person, looking at themselves in the mirror, facing who they are and accepting themselves, is part of the individual identity journey. This emerged in research story 1 and 2 as well.

DL, a transgender student, said that her understanding of her own life influenced her understanding of trans issues:

> You see, I'm transgender, myself, so, I've always been interested in gender-affirming care, because it's a need of mine. It's something I've seen in the healthcare system, as sometimes lacking, umm, and something like a hole that I'd like to fill, because it's something very dear to me as a person (DL, transgender student).

DL speaks from personal experience when describing the power dynamic in a consultation, where trans patients feel they must present in a certain way, and at times conceal their identity for fear of abuse.

> There's such a strange power dynamic there, because there's firstly that basic power dynamic of a patient and a doctor, that's kind of a standard power dynamic where you are the patient, you trust and respect your doctor, you assume that they have your best interest at heart, right? So, there's that power dynamic. Umm, then there's also the power dynamic of feeling like, firstly, some people feel like they have to conceal their identity to be palatable to the doctor, for fear of discrimination … It's kind of like trying to present yourself in the most appropriate way, where you are kind of the example trans patient, where you want to, you fit all the boxes, you know the criteria, you fit the criteria just to kind of access, because there are honestly, there are a few barriers to access, where you're scared the doctor is going to say, oh no, but you're not trans enough, to get gender-affirming healthcare, so, you shouldn't be allowed to be here… (DL, transgender student).

This is such a harrowing account and such an indictment on the medical profession, that some TGD people feel they have to present in a certain way “to be palatable to the doctor”. The description of the power dynamic in a consultation is fascinating, with the two levels of firstly doctor-patient with the added aspect of being vulnerable as a trans patient, unsure if they will be able to access care.

AA learnt from their own experience as a trans person:

> I want to later when I qualify as a professional, maybe be someone who, maybe not change the whole world, but make a difference in people’s lives. Queer people are still marginalised in the medical setting. I want to be someone who practices gender-affirming care to help those around me, and I am also transgender myself, so I think it’s just more personal for me, I can relate to it (AA, transgender student).

For students who are not trans identified, negative experiences as patients also contributed to reflection on what affirming practice is. J’s own experiences of visiting doctors have been negative, not affirming of her as a person, and inspiring her to be better. This is an example of what is not GAHC.

> So, just going to the doctors myself, it’s just very like clinical, there’s no real understanding of the person. It was just, each time we went to a doctor, all I have been picking up is, Sho! I don’t want to be like that, or like, I can’t be like that, making these mental notes of how not to be. I just want to be someone that if they came to you, it’s like, wow, what a relief because there’s so many bad like experiences of going to doctors. I’m just consciously making notes, almost every time I go to a doctor, each time it like shapes me differently, just like you can do this better (J, cisgender student).

There is the concept of relief in this narrative as well, that was discussed in section 5.3.2.4, of patients having had negative experiences, and J wanting to provide an environment where the patient will be relieved that the doctor accepts them for who they are.

TB’s experience of being a patient was not affirming, and this influenced her view of what GAHC is (and is not). She describers going to a gynaecologist, where assumptions were made, such as that her sexual partner would be male. In research

story 3, D also tells of an experience of a doctor who made assumptions, leading her to think about what affirming practice means.

There was significant learning from own lived experience, both in terms of exploring own gender identity, and experiences of accessing healthcare. The negative experiences demonstrate what is not affirming care. In addition, several participants described learning from the experience of partners or friends. This will be discussed in the next section.

5.3.3.2 Sub-theme: Lived experiences in social circles

Participants learnt different things from the experience of partners or friends. They learnt about what transgender is, the importance of being affirmed, the process of transition, and the difficulties accessing GAHC.

N started learning about hormone treatment from a friend who was transitioning, and a doctor that the friend was in contact with, who explained to her what GAHC was about.

J learnt about what transgender is from being in a relationship:

> …and it turns out that I didn't have a girlfriend, well, I thought I had a girlfriend for a few months, and then we discovered together that he identified as trans, and we had never heard about this before. It was like very scary, when we were googling like why he might feel this way (J, cisgender student).

CM learnt from friends about the importance of being affirmed:

> I have a number of friends who, some of them are non-binary, some are gender nonconforming, some are transgender… They definitely helped me to understand a lot about, umm, you know, why other people recognising you for what you are is important (CM, cisgender student).

B describes his learning about GAHC through observing the experience of friends who transition, as seeing through a completely different lens. This is told in research story 5 in more detail.

L learnt about transitioning by watching the journey of their best friend, as well as learning about the challenges of navigating the health system:

> I think it's a big part of it, is also watching their journey, from identifying as a gay boy, in high school, and then identifying as gender non-binary, and then eventually coming out as a trans woman and I think having had that first-hand experience, watching somebody that you love and also watching them navigate the healthcare system, as a poor, trans black woman, is also a big inspiration (L, cisgender student).

J learnt about the difficulty accessing affirming care through the experience of her transgender boyfriend who is reluctant to go to a doctor, "where he's not a hundred percent sure that they're welcoming". She describes her frustration with care that is not affirming: "…being with someone who has their gender like not constantly affirmed, it just makes you so heightened, like wow, that's horrible, as a doctor you shouldn't be like that, or you should be inclusive!" (J, cisgender student).

For TB, learning about the difficulty accessing affirming care happened by being in a relationship with someone who is non-binary:

> And I was actually in a relationship with someone who is non-binary, and I remember how much they just struggled with feeling, umm, kind of alien, throughout the whole system, and feeling like there was no healthcare that was aimed directly towards treating people like them (TB, cisgender student).

These students were indignant at the care that their partners received. This has an impact on their own PIF, knowing what kind of care they think should have been provided.

In conclusion, closely observing the journey of a TGD person, including their difficulty accessing GAHC, is a powerful learning experience. I have experienced that myself, watching a friend's journey from when she first discovered that there is a term for what she experiences, to accessing care. That was one of the many times that own experience as narrative inquirer aligned with what I have learnt from the field. Some participants described learning from the lived experiences of patients, which will be discussed next.

5.3.3.3 Sub-theme: Lived experience of patients

The three cisgender practitioners all described learning about GAHC from patients. For two of them, it was activists who came to them as patients and motivated them to start learning about GAHC. In research story 3, D tells how an activist friend encouraged her to learn about hormone treatment.

SM describes her experience learning from patients:

> It was a patient, that actually got me started. A trans man walked in with a sore throat, but because I was seeing him for the first time, he happened to tell me that he was trans. He worked for Gender DynamiX, and I was very interested. And because he found me to be interested, he sent me some information, and one or two patients. I guess he must have found the way I asked questions, umm, you know, supportive rather than judgmental. It is so horrible to think that people feel judged about this (SM, cisgender practitioner).

When I asked about awareness of the importance of language, SM said, “I think it was because my first few patients were activists and could very clearly articulate how important pronouns and body parts and assumptions were” (SM, cisgender practitioner).

N tells a story of a woman presenting at a Rape care centre and being misgendered because of her masculine appearance and deep voice, that was significant in her learning about gender and not to make assumptions.

> So that moment struck me a lot. That taught me you know, never to judge anybody, and never ever do you assume anything, because people are who they are. When you look at this case, this person is cisgender with masculine features, and they are still comfortable with it. So, it taught me a lesson that sometimes gender conforming features don’t necessarily mean you are that gender. Gender is who you are, it’s what you feel. Yes, it’s who you are inside, not what people see, not what is presented. Yes, society accepts how you look, and how you present or how your voice sounds, but gender is not about all those things, but who you are deep within yourself (N, cisgender practitioner).

In many of the narratives, the indignation at care that is not affirming, formed part of the PIF. This included personal experiences, the experiences of friends, and for students the experience with patients.

DL, who is a transgender medical student, describes an experience where a trans woman was being misgendered by the registrar, and how powerless she felt as a medical student. She uses this to say what GAHC is not:

> I can think of a specific moment that made me realise how I don't want to think about it, gender-affirming healthcare. So, I was on intake, in the hospital I was working in, and then there was this patient that was referred to psychology. On her folder it was kind of circled, like her ID sticker kind of said male, and it was circled and said, 'prefers to be female', like that alerted you that she is a 'she' in her pronouns, but like in such a strange way, like, she sees herself as, as opposed to, she's trans, she's a trans woman and just saying that. Kind of like saying she's not okay and she's seeing herself as female was kind of framed in that light, and then I saw a registrar come to this patient, and gender her as "sir" and "mister", and I was like, so the note that was made on the folder meant nothing, there was no gender affirming kind of checking in with the patient, despite the note, you know. Just, because she was presenting as female, and I could see that, and then I was quite uncertain at that point, I was in my fourth year, and by that time I had already transitioned, so I was kind of already sensitive to it and seeing people like me, and I was really disappointed in that thing. I felt so powerless, because I myself couldn't now step in and say, no! I probably could have, but I was just like, I'm a student, I'm kind of under this registrar who's doing this thing and I'm myself trans and I don't want to be misgendered and I don't want to be put on the line as this person who is a fourth year student trying to correct a doctor, so that was kind of one of the moments that really highlighted why it is so important to be a gender-affirming healthcare practitioner (DL, transgender student).

This is a painful experience for the student, who could see how this trans woman was not recognised for who she was, firstly by how it was indicated on the folder, and secondly by the registrar misgendering her. Because of the student's own identity as trans, she could imagine what the patient was going through. The hierarchical relationship between her as a fourth-year medical student and the registrar made it very hard for her to even consider saying anything. Hierarchy in medicine will be further discussed in theme 6.3.1.

JL also described an experience where a transwoman was misgendered, that will be elaborated on in research story 4 in Chapter 6. This experience led him to read more about GAHC.

The experiences with patients described in this section had profound meaning for the participants as a stimulus for learning about GAHC. For the practitioners, it made them aware of a knowledge gap in themselves, whereas the student narratives focused on observations of doctors misgendering patients and wanting to provide a different quality of care. The next section will look at the role of student societies.

5.3.3.4 Sub-theme: Student societies

For the students interviewed, student societies played a significant role in their learning, outside of the formal curriculum. The student societies hosted events where GAHC was discussed. In addition, the societies provided safe spaces where LGBT students learnt from each other. To avoid identifying specific institutions, the names of societies will not be mentioned. I used the student societies to assist me in finding participants for this study. I was looking for a purposeful sample of students who are interested in becoming gender-affirming practitioners, and the members of these societies are the ones with such an interest, so it is in a way to be expected that the participants will talk about the student societies.

HM describes an event where a transgender doctor gave a talk:

> I'm part of the […] society on campus, one of the events that was a transgender doctor, just a GP, but she happens to be trans, and it was one of the most interesting idea-shaping moments that I have had in my medical career, not necessarily from the curriculum perspective but external influences. I think that was one of the moments of hearing the reactions that people tend to have and the space that is not necessarily kept within the medical community for people to be comfortable within themselves (HM, non-binary student).

J describes a talk about transgender health:

> A […] society event, where they had a transgender talk, in 2018, and then they got in the doctors that did gender affirmation surgery, and that like blew my mind, and that's

> so cool, like making such a big difference, and they brought Gender Dynamix [NPO] (J, cisgender student).

DL learnt from workshops held by a student society:

> What I definitely leaned on, in terms of my medical understanding of trans issues has been societies at med school, so particularly the society that I have learnt a lot from is […], they basically deal with sexual and reproductive health, and they also deal with transgender people issues, and they deal with sexual and gender minorities. That's been a great learning tool for me, where, they often had workshops and things, outside of curriculum, but at med school, to kind of learn and engage with (DL, transgender student).

All three these students use descriptions indicating that this was significant learning for them, "one of the most interesting idea-shaping moments", "blew my mind" and "a great learning tool".

One student specifically noted the importance of learning from trans students:

> […] hosted events and did content around trans inclusive healthcare, and we made the point that trans people should lead the discussion and should give us the knowledge, on how we as healthcare providers can treat them better, and I think that's when I really thought about it, I will be the doctor, who has the potential to actually make a difference (L, cisgender student).

The societies created safe spaces where students learnt from each other, by having discussions and listening to individuals' stories.

> At our campus, our LGBT student society is quite a tight knit community. It's very pro-active, and we have lots of discussions. Especially because we're all going to be healthcare practitioners, as LGBT people ourselves, to sort of have those conversations within ourselves, or within our own circles, have people who have read different things, who have had different experiences come together and have those kinds of conversations. So, the informal learning between students, amongst each other, is also quite important. And that has influenced my thinking a lot as well (JL, cisgender student).

The societies were also spaces to connect with like-minded students who are interested in social justice. J described this as “people who think like you and want the future you see” (J, cisgender student).

In summary, student societies featured in the narratives of most of the students, as a significant place to learn about GAHC, outside of the formal curriculum. The student societies were seen as safe spaces where LGBT students could learn from each other and meet like-minded people. It appears that for these students, the societies filled a gap in their knowledge and exposed them to content not learnt in the formal curriculum. It would only be students who are courageous enough to belong to such societies and to attend events, who would be exposed to this learning. In Chapter 6, the formal curriculum will be explored, with the argument that all students should learn about GAHC. The next section will discuss the theme of learning from lived experiences in the context of the literature.

5.3.3.5 Discussion: learning about GAHC from lived experiences

There are multiple factors that influence the shaping of a professional identity, as depicted in the schematic representation (Cruess et al., 2015). Personal experiences, as well as that of friends can play a significant role. Wald describes the role of relationships in PIF and identifies interactions with patients as a key factor (Wald, 2015a). Clinical experiences can play a significant role (Bleakley & Bligh, 2008).

For many participants, the start of their journey of learning about GAHC was either their own experience or contact with a TGD person in their social circle or as a patient. A South African study of healthcare professionals’ experiences of providing GAHC (Spencer et al., 2017) reported that often the gateway to GAHC was a personal connection to the TGD community, and for some it was a specific patient or another healthcare professional that initiated their pursuit of information. Snelgrove et al. (2012), found that contact with a trans patient provided “an instigating event for physician reflection and education on the healthcare needs of this patient group” (Snelgrove et al., 2012, p. 4).

For the TGD participants, the process of learning included embodied knowledge, that they experienced the need for gender affirmation themselves and can imagine how difficult it could be for a TGD patient to access care. This brings a deeper understanding about GAHC than what a cisgender professional would have. It is a key aspect of the transgender person's professional identity, that they have intimate knowledge and insight about gender affirmation. An article on becoming an affirming therapist describes that cisgender therapists have more work to do to on the journey to become affirming than TGD therapists (McGeorge et al., 2021).

For cisgender students and professionals, learning can happen through the lived experiences of friends and patients. Participants who identify as gay or lesbian, may have more interaction with TGD people by being part of the LGBTQIA+ community. They may also have a deeper understanding because of being part of a minority group and having experienced discrimination, as described by D and TB when they accessed healthcare as lesbian women. For students and professionals where direct interaction with TGD people has not been part of their journey, hearing or reading narratives by TGD people can be a useful way of learning. This will be discussed in theme 6.3.5 "The voices of the affected need to be heard".

In many of the narratives, the indignation at care that is not affirming, formed part of the PIF. Transformative learning (Mezirow, 1997) has been described to happen when unsettling experiences or "disorientating dilemmas" can change the way we view the world, through critical reflection (Van Schalkwyk et al., 2019). The students described narratives of care that was not affirming, reflecting that this is not how they would like to treat patients.

From learning about GAHC through lived experience, the discussion moves to another way in which participants learnt, through learning online.

5.3.4 Learning online – filling the gap left by undergraduate training

The practitioners interviewed did not learn about GAHC during their formal training and described that they found information online. Searching for information on GAHC through the internet is described in all three research stories. As there was

little information on GAHC available in South Africa at the time, participants researched how GAHC is practiced internationally.

N heard about gender-affirming hormones from a friend who requested help, and the found information online:

> Then I went on to read about hormones, then I started seeing there were organisations online, and this was like a huge field, endocrinology, and then that's how I started learning about it. And then I started doing some online courses, about dosing, those were the first people that I started helping then (N, cisgender practitioner).

K got information about GAHC "predominantly through reading and going on the internet, getting journals, studying research" (K, transgender practitioner).

SM had worked in the UK at a sexual health clinic and learnt to be non-judgemental:

> I worked in a sexual health clinic, in the early HIV days, and then a very busy sexual health clinic, before I became a GP there, and so I guess there I learnt to completely suspend any prejudice or judgment, and just treat people for who they were (SM, cisgender practitioner).

She then learnt about GAHC from NPO guidelines that were available online, and from support provided by a colleague.

Student participants also mentioned learning in online spaces: "Most of what I find in terms of my learning has been via online engagement with people on Twitter, on social media platforms, and engaging with other trans people" (DL, transgender student).

This is different from the learning of the practitioners, who were looking for information, searching for guidelines and articles online. Students referred to learning about what transgender means and what GAHC is, through social media. There has been an explosion in the amount of information available online, and that young people have access to. When I think back to the time that we developed the first hormone guide for South Africa in 2013 for Gender DynamiX, there was much

less information available. We were able to access international guidelines to assist in the writing of that guide.

In a South African study of healthcare professionals' experiences of providing GAHC (Spencer et al., 2017), participants reported that transgender health-related topics are largely absent from health sciences curricula. They described learning from nationally and internationally produced guidelines and academic journal articles. These sources of information would be accessed online, which is similar to the experience of participants in this study. In a Canadian study of barriers to providing healthcare for transgender patients (Snelgrove et al., 2012), lack of training was also identified as a barrier, and physicians specified the need for readily accessible information through efficient media, such as the internet. The situation in South Africa is still that there is a need to find information on GAHC online. The SAHCS Gender-affirming guideline (Tomson et al., 2021), has proven to be a very useful online resource.

5.4 Schematic representation of PIF for plotting the themes

Cruess et al (2015) published a schematic representation of professional identity formation (Cruess et al., 2015). If the themes are plotted on this graphic representation, it would look like this:

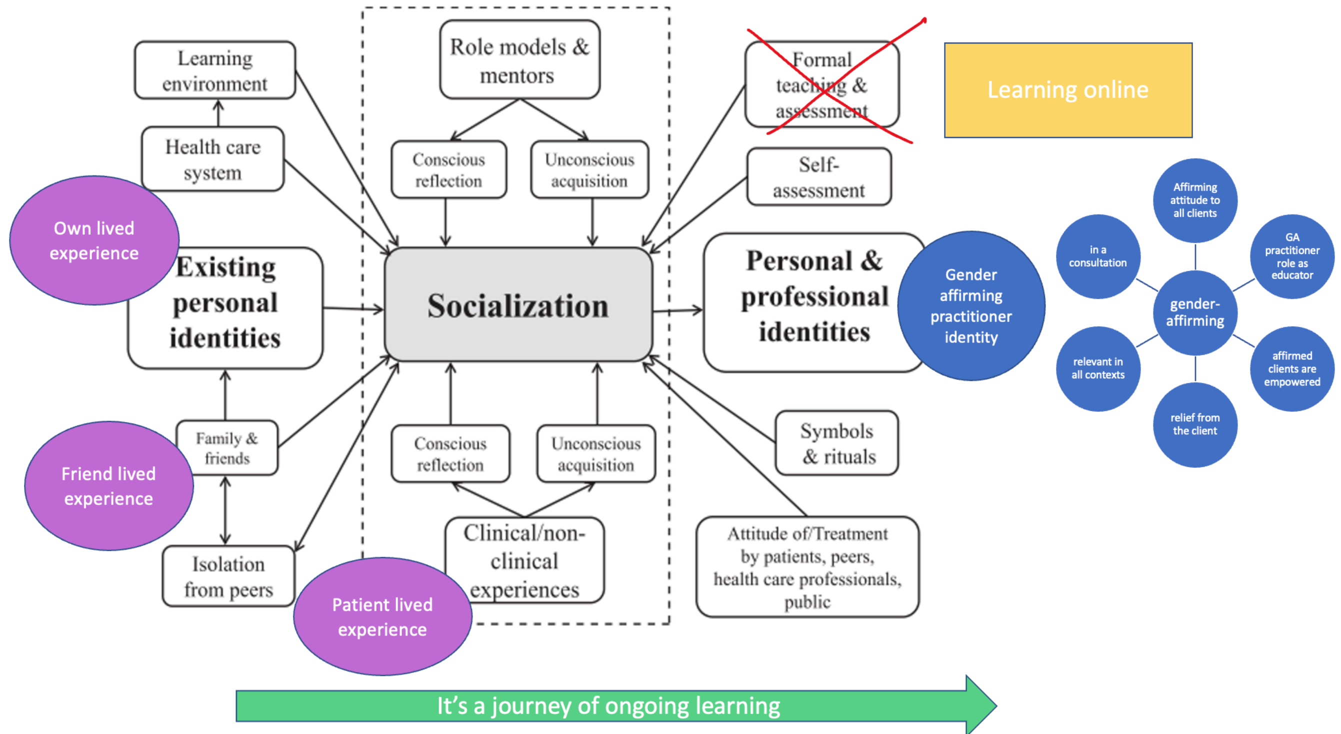


Figure 14: Themes for objective 1 plotted on the graphic by Cruess et al. (2015). Source: author plotted themes on the graphic published by Cruess et al. (2015).

The arrow at the bottom indicates the theme of a journey of ongoing learning.
I am looking specifically at the PIF towards a gender-affirming practitioner identity. What this may look like is described by the theme "affirming in every space". Significant learning took place through lived experience of self, friends, and patients. This links with the existing graphic that indicates existing personal identities, the impact of family and friends as well as clinical experiences.
The practitioners that I interviewed, did not learn about GAHC through formal teaching (top right in the graphic). They learnt from accessing materials and literature online.

The schematic representation indicates that individuals enter the process of socialization with existing identities and emerge with both personal and professional identities (Cruess et al., 2015). A health professional can have multiple personal and professional identities that are expressed or operationalized depending upon the context (Cruess et al., 2019). For this study, the focus is the aspect of the emerging GA practitioner identity.

5.5 Summary

In this chapter, the spotlight has been on the process of PIF of GAHC practitioners and students. Participants described this as a journey of becoming over time rather than a destination, with two prominent aspects, namely the attitudinal and knowledge aspects. Being gender-affirming was unpacked as an affirming approach to every consultation, as a lifestyle. Participants had learnt from lived experience (their own, that of a friend or patient) as well as from student societies.

The research stories are individual accounts of becoming. An important aspect for the transgender participants is being able to look in the mirror and seeing and accepting oneself. The process of becoming a gender-affirming practitioner requires confronting pathologising perspectives, to come to a place where TGD people can be seen for who they are, trans as identity and not as pathology. For health professionals to see the human first. In an affirming consultation, there is a different power dynamic from the traditional approach, with patients being respected for who they are, and empowered to participate in their own healthcare.

In the next chapter, I will discuss the influence of the learning environment, role models and the curriculum on the process of professional identity formation.

Chapter 6 Findings for Objective 2: The role of curriculum

6.1 Introduction to the chapter

The focus of this chapter is the second objective of this research:

Objective 2: To illuminate how medical curriculum change could enable gender-affirming professional identity formation.

Data sources for the second objective included the narrative interviews, a group discussion of medical educators as well as regulatory and curriculum documents. The first part of the chapter consists of two research stories, chosen from the second group of participants, namely the nine medical students. I chose the stories with the richest description of the student journeys of learning about GAHC through the formal and informal curriculum. The second part of the chapter describes the themes relevant to this objective, that were generated by "analysis of narrative" from the interviews of the six practitioners and nine students, as well as reflexive thematic analysis of the group discussion of medical educators. This will be followed by the document analysis as the third part of the chapter.

6.2 Research stories 4 and 5

6.2.1 Research story 4: "That should never happen to another person again!"

I interviewed this sixth-year medical student (JL) in 2020. His comments are in the context of an old curriculum that was being revised, for implementation of a new curriculum. He was in final year, while university B was in a process of curriculum review, so he would not have been exposed to the new curriculum content in first year (university B document 8). This is therefore a historical snapshot, where the current situation is already somewhat different.

> **Medical school – personal journey and journey with friends**
>
> I think I became interested in LGBT health in general, first when I came out to myself and to others as a gay man and I joined the community on campus, and I started

learning all these other things. I spent my time growing with other influences of LGBT healthcare professionals and other students and learning from other peoples' experiences. And their difficulties were enlightening for me to say the least. Then I wanted to do a research project, into LGBT healthcare, and I started looking up information and started reading articles and things, and I realised how sorely it's lacking globally but also in South Africa, and I tried to do an elective in gender-affirming care last year, and honestly just finding someone who did that kind of work was very difficult for me. And I realised, that's where I need to start, that's a space, it's a hole that someone needs to step into. And the more I started reading about it, the more I became interested in myself stepping into that space.

I think, you know, it's a difficult process in the beginning, for anyone to accept themselves and come to understand that there is this much broader community that you get to be a part of. Finding yourself within that, that already is difficult, but then once that's happened, it's also exploring the others within that, because as much as it takes you a long time to solidify where you are, and how you identify, then you need to come to terms with everyone else. Let me say, you don't want to be discriminated against, and then you know, you want to make sure that you don't discriminate against anyone else. And that for me, was a learning curve, in the beginning. One of my friends is gender-nonconforming, and it took me a good week to start saying 'they' properly, without thinking about it. Using they as a pronoun. So now it's also when I have discussions with other people, and we get to the topic of gender-affirming care, and using the correct pronouns, and subconscious discrimination, I sort of understand how difficult it is for people to make that adjustment, if they have not thought about it before.

For example, in a class of future healthcare practitioners, there will definitely be a few LGBT people, there will be a few people who need gender-affirming care, but there will also be quite a lot of people who have never been exposed to an LGBT person, to a transgender person. And they don't have any friends who identify like that, they're not part of any society, that has this kind of discussion, and so it's so easy to go through six years of medical education without ever having this kind of conversation. Never getting to understand someone else's experience, and that for me, is something that is important, that shaped my thinking, when other people talk to me, and I learn from them.

Medical school – societies

At our campus, our LGBT student society is quite a tight knit community. It's very pro-active, and we have lots of discussions. Especially because we're all going to be healthcare practitioners, as LGBT people ourselves, to sort of have those conversations within ourselves, or within our own circles, have people who have read different things, who have had different experiences, come together. So, the informal learning between students, amongst each other, is also quite important. And that has influenced my thinking a lot as well.

Experience with patients

I was on my ENT rotation, we had a patient who was a trans woman, and she also had something interesting, she had a really large cholesteatoma, so the Prof wanted us all to see it, so he called us all to the room. This patient was busy transitioning, and her ID still had her deadname, her male name basically, and Prof kept referring to her using wrong pronouns and it made her visibly uncomfortable. It made me uncomfortable, and it made me angry, that you know there was a clear woman sitting in front of him, in front of a group of students, like twenty of us at least, and he was just, [sigh], it was horrible to experience. And it made me angry and made me want to make sure that that never happened to another person again. And that's actually when I started reading more about gender-affirming care, and how to start, and this sort of unconscious discrimination, because I don't even think he knew that he was doing anything wrong, because on the folder, in front of him it said, you know Mr John, whatever, and he probably just ignored everything that was going on in front of him, like in the patient. And that was also a problem, because no matter what the folder says to you, you are still dealing with a patient in front of you, there's a whole person outside of their folder. And that's what really started to shape my thinking and my attitude towards it.

Medical school – curriculum input and gaps

Throughout the curriculum, I kept waiting, for some sort of mention of gender-affirming care and LGBT healthcare and how important that kind of advocacy is from health professionals, as well, and it's almost disappointing, when you get to the end of that part of the programme, and it hasn't happened yet. Ya, that was difficult for me and that's sort of also why I decided that this is something that I need to do. It's a part of changing the face of healthcare in this country and globally, that I really would like to be a part of, because it is so important.

> From the structure of the curriculum, GAHC wasn't mentioned, but I think giving us the opportunity to do an elective, and to do a self-driven research project, I think I took the curriculum and made it work for me in that way, in that I got to do those things. But only because I wanted to do. And I don't think that was particularly correct either, because for example if I am not interested in cardiology, I still need to rotate through there, I still need to learn it. So, I don't think it's fair to say, if you don't have a particular interest in LGBT healthcare, it's not something that you need to do, because everyone is going to treat an LGBT patient at some point.
>
> And I think that starts within the undergraduate curriculum, to change that. From the beginning. I don't think you need to be a specialist in ENT who happens to see a trans patient one day before you start thinking about being gender-affirming and avoiding discrimination. Because that patient starts at the GP and if she felt discriminated against, there, she would never get her cholesteatoma fixed, because she'd be completely lost to the system.

6.2.2 Analysis of research story 4

This story is about a final year medical student who is deeply disappointed in the formal curriculum but managed to do his own learning through an elective and the student society. JL recognises the importance of GAHC, describing it as “a hole that someone needs to step into” and emphasises that all students need to learn about LGBT health. He sees GAHC as an aspect of LGBT health, and not as a separate thing. His own journey included coming out as gay. Using the metaphor from research story 1, he needed to look into the mirror and accept himself. This then led to him learning as part of a student LGBT community, about sexual and gender diversity. He could learn about the attitudinal aspect of being gender-affirming as well as the knowledge aspect, from the student society. This gave him a heightened awareness to recognise the misgendering of a patient.

JL's narrative of the misgendering of a patient during his ENT rotation is a powerful example of what GAHC is not. DL told a story of misgendering by a registrar as well, in 5.3.3.3. These are examples of clinical teaching contradicting the values of diversity, as well as an aspect of the HC with the authority of the professor who misgendered the patient implying that GAHC is not important. JL reflects on how

patient experiences like this can affect access to healthcare, resulting in a patient being "completely lost to the system".

Descriptions by patients of being misgendered is found in the literature. In a USA qualitative study of positive and negative clinician-patient interactions amongst TGD persons, participants reported negative interactions such as being misgendered and transphobia (Baldwin et al., 2018). An Australian qualitative study also reported disrespectful attitudes by healthcare professionals, misgendering and 'dead-naming' (calling the person by their previous name) (Haire et al., 2021). These experiences are described as distressing, which is something that JL recognised and pointed out in his story. The undergraduate curriculum framework proposed by Ellaway et al. (2022), specifically mentions that students need to have a clear understanding of "Sources of gender-related trauma for TGD patients (including but not limited to: gender dysphoria, pronouns and misgendering, dead-naming, denial of care, stigma, stereotyping, transphobia)" (Ellaway et al., 2022, p. 41).

6.2.3 Research story 5: "It shattered my pre-conceived ideas."

I interviewed this fifth-year medical student (B) in 2020.

> **Medical school – personal journey and journey with friends**
>
> I think my interest in gender-affirming care comes from combining two aspects, my being a medical student, and my being someone who knows trans people, has trans friends, and is interested in social justice. I think as a future doctor, I'm positioned in a unique spot where I can be a provider of gender-affirming care. And that's quite liberating, because doing the hard activism, the advocacy and all of that, I think it's very important, but what does it mean when there is no-one to provide the care at the clinic? So, I think my interest is very much around, being someone who provides that kind of care, because I've seen what it does for trans people, I've seen how incredible it is. So, I think I'm coming from a point of where do I fit into the bigger scheme of things, and where can I play a unique role?
>
> I think I have grown a lot, in a very short amount of time. I remember in first year, a friend of mine just started testosterone, and she was like, he was like, hey, don't you want to come and help me inject? [laughter] And I was just like, six months in, and you know, "you are going to be a doctor, you must learn!" He helped me, come, let's

go, this is how I do it, and watching him do that and coming to himself in a very different way. I think, you know, it's one thing to know your own gender identity, but I think once your body starts looking, feeling, moving in the ways you want it to, that's like, so phenomenal. I remember once when we had a conversation around pronouns, just that was already so affirming for him, that was revolutionary. A lot of the time people talk about gender dysphoria, and he introduced me to this idea of gender euphoria, "when you guys call me by these pronouns, it makes me so happy and I feel so amazing", and I think I was just watching that. I think, we live in a society where gender ideals and norms are always thrown onto people, and being assigned a gender at birth, so that's always like, thrown onto you, and when we affirm people's gender, it's almost to say like, no, you don't have to do this, you know what is best for you, and what that looks like, and these are the ways in which we can help you come into that.

I have been so lucky to have been able to see this process, from a completely different lens, it shattered all my pre-conceived notions. And then to go and read and relate it back to a lived experience of watching someone moving through that process. I think it's one thing to be able to hear a lecture or see articles that say these are your options for gender-affirming care, but once you see what it can do, the transformation in people's lives, I think then you understand the gravity of it, and how important it is, to be able to provide that.

Medical school – curriculum input and gaps

You come in and you have ideas around what does it mean to be a doctor. I think I was quite lucky to be at [university A] because of for example with the first- and second-year programmes, they really like revolutionised the way I was thinking about the world, right? Because I think when you come in, and you are like, as a doctor, it's just about prescribing, you are all about sickness, and I think there I learnt, like there's more, oh, having the language of human rights, to actually think about it critically, and to think, I can be someone who is part of accessing, or allowing or not allowing someone human rights. And that's so helpful, even in the hospital, when we choose to see or not to see a patient, that's quite an exercise of power, so that's what I was grappling with at the time.

A lot of medical students are quite conservative, so you come to a point where your mind is blown by how big the world is, the constitution, human rights, all these exercises, I remember we did one exercise where we were talking about dignity, and

this is before I actually saw patients, so I was thinking from a very different lens, I was, like, dignity, everyone deserves dignity and care. I think in second year we do [a Humanities course], and now suddenly there's more language. And I think there is so many levels, like at the same time you are still doing anatomy, physiology, you are still trying to pass, but suddenly, you're thinking so differently. But also, on campus and in the culture, where I think it changes the way we interact with one another on campus, and suddenly people are having conversations, and in the context of fees must fall, and what happened in our campus and we were all thinking around activism and what does that mean, as future doctors?

In third year I started interacting with the curriculum change working group, so obviously there I was looking more from a like decolonial lens, but I also began to see the connections between gender as a colonial construct, as something that comes here, and I think that sometimes people have these ideas that[sigh], trans, gender-nonconforming, these are all western concepts, [laughs], and I think having to be able to read decolonial texts and think about genders in that context, it changes everything. We have so many countries in Africa where people have different genders outside just a man and a woman, and it's normal and it's culturally accepted, so I think that's where my thinking of curriculum started. And now I look back and I look at my curriculum more critically.

It's obviously who decides what is curriculum, what is deemed knowledge, what is valuable knowledge, that all comes back to who is in power. And I think, what it means to say is that, I think sometimes our curriculum doesn't teach us to be critical enough, it doesn't teach us to think about when things happen it's because power has played out somewhere, and in particular, no-one lands up in a particular place, like floating there, things have been shaped and made to be in particular ways, and I think it would be so meaningful if, so it's like on the one side power shapes curriculum, but I also think that curriculum has the power to let people shape the world. I think when people are allowed to see the connections, maybe it's about being given language. We're lucky to be at [university A] where curriculum has like, and I know for quite a few students, I mean if you really open yourself up to it, it can be very transformational, and you can come out like looking so different.

6.2.4 Analysis of research story 5

In B's story, there are different learning spaces, and different things that he learns about, that he sees connected to becoming a gender-affirming practitioner. Significant learning happened for him through closely observing the gender affirmation journey of friends. It is interesting to note how B corrected himself with the pronoun of the friend, while telling the story about the injection, "and she was like, he was like…" For him, this learning was at a deeper level than a lecture or reading about GAHC. Learning from lived experience of friends has been discussed in more detail in theme 5.3.3.2.

He describes a mind shift that he initially thought being a doctor is about sickness and then discovers it is about much more. Learning about human rights and power relations had a profound impact on how he sees the world. It was like learning a new language. This is an example of the positive impact that the formal curriculum can have.

B refers to the context of "Fees must fall", that influenced how he thought about activism and what it means for future doctors. He views being an activist as both doing advocacy but also the practical aspects such as provision of GAHC. The "Fees must fall" movement has had a significant impact on discourses about curriculum, resulting in documents such as the UCT Curriculum Change Framework (UCT Curriculum Change Working Group, 2018) that will be discussed in theme 6.3.2.

The curriculum change working group was another learning space for B, expanding his understanding of gender as a colonial construct and of decoloniality. He became very aware of power in the curriculum and says that the curriculum does not teach medical students to be critical enough. Jacobs et al. (2020) describe the importance of developing critical consciousness in medical students in addition to their clinical competence (Jacobs et al., 2020). Critical thinking and reflection will be discussed in more detail in theme 6.3.6. Following the analysis of research stories 4 and 5, I will now discuss the themes generated by analysis of narrative.

6.3 Themes from the narrative interviews and educators group discussion

This part describes the themes relevant to the objective "To illuminate how medical curriculum change could enable gender-affirming professional identity formation", that were generated by "analysis of narrative" from the interviews of both practitioners and students, as well as from the group discussion of medical educators. The medical educators discussed the initial findings from the narrative interviews. They will not be identified as individuals as the focus is on what emerged from the discussion.

The first group of themes looks at the curriculum from different angles, in terms of describing current realities: the medical school environment and how limited the curriculum is regarding GAHC. The second group of themes look to the future, with participants imagining inclusion of GAHC in the curriculum. The themes will be viewed through the lens of PIF and from a critical pedagogy perspective.

Table 4: Themes relevant to curriculum

Current realities	**Medical school environment, hierarchy, and power** Sub-themes: the tension of "science" vs "softer skills" and emotional intelligence; Curriculum development and power
	Curriculum critique from students: "the curriculum is quite limited"
The future: imagining GAHC included	**The potential of curriculum**: "revolutionised the way I was thinking about the world"
	Forging gender-affirming practitioners "changing the lens, of how we view our patients"
	"The voices of the affected need to be heard"
	Reflection "how to give a damn about people with experiences different to your own, that only comes out when you do some introspection and reflection"

	Role models "it isn't just enough to have a curriculum that actually deals with this when we as educators, are not role modelling this".
	Timing in curriculum and integration "formally incorporated in the preclinical or the junior years, and then followed through a spiral into the senior years"

6.3.1 Theme: Medical school environment; hierarchy and power

This theme describes the medical school environment as conservative and hierarchical, with experiences of homophobia, transphobia, and racism. In this environment, the biopsychosocial approach is not valued. Students reflected on power in the process of curriculum review. I will look at what participants said first, and then bring the literature into the discussion.

T describes the culture at medical schools as very conservative and not easy to change:

> There's a lot of entrenched conservatism in medical schools and in that didactic process, and sometimes its overt, but sometimes is just kind of very insidious. You know not so much that anyone says it out loud, but just that the atmosphere and the culture is more welcoming to conservative ideas than it is to progressive ones (T, transgender practitioner).

In research story 3, D describes medical school culture as producing doctors who think they know what is best for the patient. This she contrasts with GAHC, where the patient is in charge of their own healthcare. This is a reflection on power in the consultation, where there is a power shift as has been described by K in the previous chapter, with theme 5.3.2.5 (Affirmed patients are empowered to participate in their healthcare).

The environment in which we want to imagine curriculum change is described by B as conservative, with senior clinicians and students making assumptions about queer students, and misogyny and homophobia present. B also describes a feeling of powerlessness in the face of this: "The way that people experience gender,

depending on the assumptions that people make about you, is so different…. you also feel like, [sigh] what am I going to do?" (B, cisgender student).

J (cisgender student) describes fellow students who are conservative and felt uncomfortable with what was taught [in a humanities course] so did not engage; others engaged but still feel uncomfortable. There is a hierarchy at medical school, and in her experience as a "person of colour" (her words), straight white males are more confident to ask questions, whereas many "women of colour" (her words) do not feel comfortable in the space.

In addition, DL describes a hierarchy where medical students "can't quite question it because you just don't know enough." She said:

> There's definitely a power dynamic that's present in medical school, so in the curriculum in particular, where there's this hierarchy, this medical hierarchy particularly in clinical years, where it's the students, it's the fourth-, fifth-, sixth-year, the intern, the medical officer, the registrar, the consultant, and we like go up this hierarchy of power, who kind of has a say at the end of the day. I wouldn't approach this registrar or try to correct them because I'm just a med student. I'm just the person who needs to put up drips and take the bloods, [laughter], and mind my business and do my best to impress the consultant on the ward round, and that's kind of my job (DL, transgender student).

HM, who identifies as non-binary, describes a lecture where they felt very uncomfortable due to the terminology used such as hermaphrodite, but no students spoke up: "We were second years, and it was I think first or second month of being here, so we were all kind of, very scared and uncomfortable at this point" (HM, non-binary student).

They go on to describe the culture at medical school as not supportive, with underlying unspoken racial tensions and micro-aggressions. HM points out the power dynamic where students are scared to speak about sexist comments, because of the hierarchy:

> There have sort of been sexist comments that have been thrown around in the hospital setting, and as a student you're sometimes not quite sure how much to ignore, how much to take, because these people are responsible for your marks after

> all. So, I think that's the type of power dynamic that I have dealt with (HM, non-binary student).

CM describes sexist and racist behaviour as well as LGBTQ+ people not feeling accepted on campus:

> Some of the male doctors especially the older ones can be a bit arrogant, towards our female colleagues, and definitely towards some of our black female colleagues, umm, and it's not even necessarily something that seems to be very intentionally done, but just something that is off the cuff, which is in many ways worse (CM, cisgender student).

The experience of AA is that there is still prejudice: "Queer people are still marginalised, in the medical setting, there's still some prejudice" (AA, transgender student).

In the educator group discussion, a participant described how difficult she found it that some students were very conservative: "I'm facing 250 students where some are very conservative and push back saying 'Stop pushing your liberal agenda'... not understanding liberal, progressive, social justice...I would say that at least 60% of my classes push back in terms of values".

From the interview participants and the medical educators' discussion, a learning environment is described that is conservative in the sense that there is little openness to diversity. Students describe a hierarchy that makes it difficult to challenge injustices such as homophobia, prejudice against queer students, racial and gender discrimination, because their seniors are the people responsible for their marks.

Cruess et al. (2015) included the learning environment as one of the factors influencing PIF (Cruess et al., 2015). A recent study on PIF of medical students by Findyartini et al (2022) also identified the learning environment as an important factor and found that the hierarchical nature of medical education can inhibit the PIF process or shape PIF in particular ways (Findyartini et al., 2022).

Of the ten main negative areas identified in a literature review of negative aspects of the medical school learning environment (Damiano et al., 2019), five were described by the student participants in this study: unprofessional behaviours (such as misgendering a patient in research story 4); sexual discrimination (such as HM pointing out that students do not speak out against sexist comments); minorities discrimination (such as AA saying queer students are marginalised); racism (as described by HM and CM) and homophobia (as described by B). Although it has to be accepted that the medical school environment is a microcosm of society and is not immune to discriminatory attitudes present in wider society, we do want to create an environment that is conducive to PIF.

A 2019 Report of the Faculty of Health Sciences Mental Health Working Group at UCT, titled "Report on the Faculty-based engagements with stakeholders: understanding 'uMgowo'", has harsh criticism of the university culture as dehumanising, with emphasis on excellence while neglecting wellness and self-compassion (Galvaan et al., 2019).

> Students reported feeling pressure to acculturate their own familial and community ways of being with discordant normative professional knowledge, practices, and ways of being within the FHS. They felt that these are pervasively reflected in dehumanising processes embedded in teaching, training, managerial and administrative practices in the faculty and often times, in the relationships between peers, and other members within the faculty (Galvaan et al., 2019).

There is a meaningful paragraph in the recommendations section of this document that specifically relates to PIF:

> **Personhood in Professionalism**: Students recommended that training should forefront the importance of personal development as part of professional development. Developing and expressing personal identity is a part of this personal development. Currently there is little room for questioning, or invitation to explore what is taught from students' novel perspectives to provide them with opportunity to build a Professional Self which is congruent with their Personal Self. It was suggested that teaching and training be designed to encourage students to bring their diverse life experiences to their training as they move from student to health professional (Galvaan et al., 2019).

This is similar to the approach of Paulo Freire (Freire, 1970), that students bring their own life experiences to the learning encounter. The value of Freire's approach will be elaborated on below. If students find that their experiences are not recognised and validated, and they are scared to speak, it can impact on their PIF.

This report of the Mental Health Working Group describes an institutional culture where hierarchy-based bullying was present:

> The tiered system of authority, respect and personal value based on authoritative biomedical knowledge systems was experienced by many as dehumanising and dismissive of those not centred by the system. Themes that were raised within several engagements included *hierarchical based bullying from more senior to more junior clinicians, interns, and students* (Galvaan et al., 2019).

The description by DL above demonstrates this hierarchy. It has to be recognised that hierarchy is inherent in the medical profession (Vanstone & Grierson, 2019, 2022), and that it is the negative aspects such as hierarchy-based bullying and students feeling silenced that is being criticised.

In a study of medical student reflection on social accountability, Green-Thompson, McInerney & Woollard (2018) found that 'knowing one's place' becomes a negative aspect of the hierarchy in terms of advocacy on behalf of patients and in the observation of inappropriate conduct (Green-Thompson et al., 2018). They describe how students reported losing their voice, with the power differential between teachers and students resulting in students often not speaking up in order to keep the peace (Green-Thompson et al., 2018). The narrative by DL in chapter 5 (5.3.3.3), of an experience where a trans woman was being misgendered by the registrar, and how powerless she felt as a medical student, is another example of this.

A recent study of medical students' experiences of mistreatment by clinicians and academics at a South African university (Crombie et al., 2023) describe
that hierarchical relationships can lead to trainees feeling that they cannot speak out against abuse out of fear of punishment or discrimination. 78.2% of the medical students reported having experienced some form of mistreatment by senior doctors or other hospital staff. Gender discrimination was reported by 29.7% and racial

discrimination by 33.7% of the participants. The main themes described by students included condescending remarks, threats and fear, and discrimination (Crombie et al., 2023). This relates to what students have described in this study, that gender and racial discrimination is prevalent in the learning environment.

A study of the HC related to gender at a medical school in Taiwan (Cheng & Yang, 2015), described gendered stereotypes of physiological knowledge; biased treatment of women; sexual harassment and a hostile environment, as well as ridiculing of LGBT people. This resonates with what the students in this study described in terms of sexism and LGBTIQ+ students not feeling accepted.

A Canadian study of TGD medical students (K. Butler et al., 2019), reported that participants described a cisnormative medical culture with pervasive cisnormative assumptions that marginalizes the existence of TGD people. This resonates with the description from the student participants in this study.

From a critical pedagogy perspective, medical educators need to be critically conscious of power dynamics in the learning environment (Sandars, 2017). DasGupta et al. (2006) argue that the way in which educators interact with students models the way in which trainees then interact with patients (DasGupta et al., 2006). Epistemic injustice, by which someone else's knowledge is discredited (Fricker, 2007), is demonstrated where medical training and expertise are legitimized in the biomedical context, while the patient narratives are viewed as irrelevant, illogical, or unworthy (Thomas et al., 2020). In a medical education context, the descriptions of DL and HM of an environment where students are scared to ask questions, are examples of epistemic injustice. Thomas et al. (2020) assert that for epistemic justice, the teacher-as-expert model will have to shift to one where learners' experience and world views are recognised and valued.

> For educators, this will necessitate a delicate balance of understanding, integrating, and remaining true to Freirean principles of emancipation and flattening of hierarchies, while scaffolding learners into acquiring and being asked to emulate discipline-specific knowledge and skills which are based upon normative rather than personal worldviews or experiences. For example, educators can begin by making explicit that learners' worldviews are necessary, valued, and provide the foundation

> upon which they can construct a new understanding, while also asking them to question their own taken-for-granted assumptions and those within their discipline specific knowledge (Thomas et al., 2020, p. 415).

In summary, this theme of medical school environment, hierarchy, and power, reveals a picture of an environment that is not very conducive to becoming gender-affirming. Hierarchies play out in different ways in the descriptions, with racism, sexism, heteronormativity, cisnormativity as well as a hierarchy between lecturers and students. These hierarchies make it difficult for students to speak out about discrimination that they experience and observe.

Another aspect of the medical school environment that emerged from the data, is that there appears to be a tension between biomedical science and the humanities. What is considered as "softer skills" (I use the inverted commas deliberately), which would include an affirming approach, appears not to be valued by both clinicians and students. This is what I will explore next.

6.3.1.1 Sub theme: the tension of "science" vs "soft skills" and emotional intelligence

Participants used the terms "soft skills", "softer skills" and "fluffier part of the curriculum". I will present what they said, followed by a brief discussion of the term "soft skills".

T describes the pressure that medical students experience, which leads to "soft skills" being undervalued:

> I think one of the other issues is just the pressure that students are under during their medical studies and you know the focus on almost that necessity to, like, survive and to pass the exams, and you know, something isn't relevant unless it's going to be examined, which often leads to a lot of the soft skills, and I hate that term 'soft skills'; but it leads to the soft skills being undervalued (T, transgender practitioner).

In the medical educator discussion, this tension was discussed as well, where students value science more that the "softer skills" and it is not valued by teachers in the clinical years:

> As somebody who teaches in the junior years, and I try to engage with a strong psychosocial, patient centred, critical thinking process, and the push back is extreme. The students are not interested, they do not engage and the colleagues, my colleagues undermine it, so it's a systemic issue…
> The students are not interested because science is the focus, medicine is the focus... and they're not seeing the patient within their context, and they're not seeing the psychosocial issues, and they're not able to engage that.

Some participants called it "the fluffy part of the curriculum". One reflected:

> We've got to ask ourselves, as the academics, how much are we really teaching, on emotional intelligence? There's not much, there's quite a bit happening in the preclinical years, but as soon as clinical years come, then that is clearly swept under the carpet, as we can see, from the behaviour of the ENT, the behaviour of the plastic surgeon [in the research stories that were presented], so it's not something we are practicing. In Family Medicine, for us it's all about being a safe space when we're doing consultations. Are we teaching people to engage with things that they don't understand? Or are they going to be like the plastic surgeon in the narrative that says, come back in three months, so that somebody else can see the patient? So yes, it does have to do with our curriculum, but is it a knowledge thing, or does it have a lot to do with the softer skills that we are not necessarily focusing on and educating our students in?

> The so-called fluffier aspects of the consultation, the biopsychosocial approach, so I feel like, I mean whether students engage with it or not, it's part of the curriculum, it is forming part of their foundational training. When you go out into the real world of medicine the psychological and social aspects are somehow pushed down, in terms of their importance, and there's various reasons we can list, pressures in terms of time, or there's a lot of patients to see, and there's a culture that these students are having to rise up against.

This resonated with my own experience as documented in the research journal: "In Family Medicine we have been battling against this for a long time - that students get taught patient centredness in their early years, and then see something else in the wards".

Although a contested term, “soft skills” is used in the literature, specifically in health professions education and more widely in the fields of education and business. It refers to socio-emotional skills (Sancho-Cantus et al., 2023), and include communication skills, as well as higher-order thinking such as problem-solving and decision-making (Botha et al., 2023). In this study, it appears that participants refer to “soft skills” as communication skills and a biopsychosocial perspective. It is not helpful to contrast “soft skills” or non-technical skills with “hard skills” or technical skills in my view. It implies a hierarchy of skills whereas it is clear that communication skills are essential for all health professionals (Academy of Science of South Africa, 2018).

The question about whether we teach students to engage with things that they do not understand is an important one. If they come from a background where they have not been exposed to much diversity, will they know how to deal with sexual and gender diversity in a meaningful and respectful way? The question accentuates the importance of including this aspect in the curriculum.

In the medical educator discussion, the curriculum was described as very full, with little space for humanities and the biopsychosocial approach:

> So, I think the curriculum is very packed, we need to think a lot more cleverly, about how we build attitudes of patient centred care, of professionalism, emotional intelligence, and engagement with people, because the students are going to need to cross too many boundaries in healthcare, and some of these things are generic.
>
> I think the curriculum is very, very full. I feel like I teach in teaspoons. A teaspoon about alcoholism, a teaspoon about violence, and that it’s very light weight. So, there isn’t a lot of space and on top of it, it’s only a small group of the class that are engaged.

Martimianakis, et al. (2015) describe that students receive implicit messages that humanism is secondary to clinical scientific knowledge (Martimianakis et al., 2015). This resonates with the theme described in this study, that students value biomedical science more than humanistic aspects. Jacobs et al (2020) documented this tension as well in a study of South African health professions educators, where “some

respondents viewed the knowledge base informing clinical competence as the only knowledge base that mattered" (Jacobs et al., 2020, p. 125), although the authors contend that critical consciousness is as important as clinical competence. Jacobs et al (2020) argue for curricula that are responsive to issues of social justice and produce healthcare professionals that are critically conscious, and advocate for managing the tension through collaborative conversations (Jacobs et al., 2020).

Eichbaum et al. (2019) recognise the conundrum in low resource settings such as Africa, of justifying spending resources on humanities in the medical curriculum in the face of competing demands from the clinical sciences (Eichbaum et al., 2019). Still, they argue that the humanities taught in a contextually relevant way can contribute to developing critical consciousness in medical students (Eichbaum et al., 2019). Pentecost et al. (2018) offer a conceptual framework that equally values biomedical sciences and the humanities with a recognition that both are valuable for healthcare (Pentecost et al., 2018). This framework includes "an integrated understanding of history and social context, centring issues of inclusion, access and social justice" (Pentecost et al., 2018, p. 221). This is very relevant to teaching about GAHC, to have an understanding of how TGD people have been marginalised.

Any attempt to change the curriculum, even though well motivated, may be met with resistance (Cerimagic & Hasan, 2018). It has been described in this section that the curriculum is viewed as very full, and that health professions educators have different perspectives on what is important. Cerimagic & Hasan (2018) outline that resistance to change, insufficient resources, an overloaded curriculum, inefficient communication between university leadership and academic staff as well as organisational culture can affect implementation of curriculum change (Cerimagic & Hasan, 2018).

This sub theme looked at how the biopsychosocial approach and humanities are undervalued in medical schools. There was also a focus on aspects of power in curriculum development, which will be discussed next.

6.3.1.2 Sub-theme: Curriculum review and power

The power dynamic was described by students in the process of curriculum review. The power to decide what is included and not included in curriculum seemed to rest with mostly cis-heteronormative academics, with differing views from participants on how seriously input from students are taken.

B sees power in curriculum as two different aspects, as seen in research story 5:

> It's obviously who decides what is curriculum, what is deemed knowledge, what is valuable knowledge, that all comes back to you know, who is in power… so it's like the one side power shapes curriculum, but I also think that curriculum has the power to let people, like, shape the world, also... (B, cisgender student).

TB is outspoken about the power of deciding what gets included and excluded in the curriculum:

> I think there's the people who sit and decide what goes in the curriculum, they have the ability to say that they've approached the student body. They created opportunities for people to come and have engagement sessions and talk about what they wanted in a new curriculum, but I'm doubtful as to how much that will be included, because it's all well and good to have a process, and say that you took something into consideration, but the contents might be different, because, you know, the mindset of the faculty and the university body, that make the decisions, those take a longer time to change than the student body. So, I think there is huge power in deciding what gets included and what gets excluded.

She gives an example of an anatomy lecture on intersex individuals and congenital anomalies, that was approached purely from an anatomical viewpoint:

> So, it's also how it is approached and how it is placed in the system, and whether it is just glossed over, whether gender is just something that is taken as an anatomical fact, or whether it is taken as a functional part of someone's identity (TB, cisgender student).

DL describes a shift in power over time in the university, with more input from students:

> I guess they have done a lot of work on transformation and whatever, particularly at [name of university], where I study. They've done a lot in terms of getting student

> representation on the curriculum advisory committee to say, no we want to learn more about this, or this is an important thing, or students struggle with this, can we not structure it in a different way? And I guess that is where the power has been shifting over time, where student representatives can actually get input from students, represent the students on the panels and say this is what students want to learn, and this is important for students (DL, transgender student).

JL described his involvement in curriculum meetings as a student, where the decisionmakers were a homogenous group:

> In those [curriculum] meetings, it's sort of very clear, umm, where everyone's mindset is, and where their influence on the curriculum goes… Umm, and that having a more diverse group of voices that shape the curriculum could be a good place to start as well because if they've never been exposed to a diverse group of people, who've never changed their thinking, it's going to be limited, and therefore their influence on the curriculum, and changing it, to be more gender-affirming, will also be limited (JL, cisgender student).

This is a key insight, that if those with the power to decide what is in the curriculum have not been exposed to diversity, this can have a negative impact on the potential of curriculum change.

Students at both university A and B have described opportunities for students to participate in curriculum reform. Student voice has been identified as an important aspect of a decolonising approach (Le Grange, 2016) and curriculum renewal (Adam et al., 2014). In university A document 1, it is said that students "must continue to play a critical role in informing meaningful curriculum change". In university A document 3, it is indicated that the Health Sciences Student Council members "represent and make submissions which express students' views, concerns and aspirations to various committees including the Faculty Teaching and Learning Committee". In university B document 2, it is stated that "MBChB students are actively involved in the processes of the MBChB programme committee, such as curriculum planning, workshops, etc." Although there is opportunity for student participation at both universities, it remains a question of how much power the student voice is given in decision making about the curriculum, and that is beyond the scope of this study.

In the next theme the focus is on critique of the curriculum, in regard to the inclusion of GAHC.

6.3.2 Theme: curriculum critique "the curriculum is quite limited".

Two practitioners spoke about their experience at medical school as part of their stories.

T's experiences at medical school did not contribute to becoming gender-affirming and reflects experiences we would not want our students to have. This is described in research story 1 in Chapter 5, where she said she had only been taught one sentence about trans patients, formally in a lecture. D also felt that medical school did not prepare her for gender-affirming practice and that there is a huge gap, as described in research story 3.

Every medical student interviewed had critical comments about the curriculum. This is a specific group of students, a purposeful sample with a keen interest in GAHC. JL describes his disappointment with the curriculum in research story 4 and expresses concern that students will graduate without understanding GAHC. B has harsh critique of the curriculum as seen in research story 5. He is critical of GAHC just being taught in a workshop, arguing that it should be more like a thread than just points.

> So, what we get, we get that one workshop in third year, and a workshop, in fifth year, I think that's about it, you know. I think it's weird that these sort of topics, queer topics or like ideas around GBV, gets located into this one weird, this is the transformative spot, and then for the rest of our lives we don't have to think about it. So, I think it would be so meaningful if there were threads, I think now it's more like points (B, cisgender student).

J said that the curriculum did not go far enough to remodel mindsets:

> Because I think we did do quite a few exercises, like a homosexual patient or whatever, surprise task, how would you interact, and that kind of just brings up the issues, so you just see who the homophobes are in your class, and then it's kind of it's just like, don't be like that! And then we're like, okay, so all you're doing is

> exposing the wrong, but they're just gonna be like, ah, I know you say I shouldn't be like this, but there's no active remodelling of their mindsets, you just, acknowledge, letting them, I know self-awareness is a first step, but there is no facilitation of any other steps (J, cisgender student).

TB is critical of the language used and the attitude of lecturers. She argues that students need to learn about diversity in identities, not to use stigmatising terms, and how to address someone.

> There's a lot of lecturers who speak very much in a heteronormative way and where there's just lots of assumptions and there's constantly feminisation and masculinisation, and if there is something that is very important to me, that I notice in a lecture, then I like to go up to the lecturer at the end, and ask them if they're okay for a bit of feedback, and I mention you know, I appreciated that part of your session but perhaps in future would you mind being, you know, using your terminology, changing it slightly so it's more open to a diverse population? I remember when we were doing the reproductive system in second year, when we started talking about intersex individuals, when we started talking about umm, congenital anomalies within the reproductive system, I remember sitting there and feeling like we were very much othering individuals who don't fit the typical or the norm. And it was very much spoken about as if it's this sort of alien situation, where there were probably some intersex individuals sitting in our class. And there were gender diverse people sitting in our class, and I just remember thinking that we have so much to change and so far, to go (TB, cisgender student).

This demonstrates agency, where this student felt she could give feedback to lecturers in the preclinical years. This contrasts with earlier descriptions of constraining hierarchy in the clinical context where students remained silent. It is a different scenario between a class lecture, where marks would depend on an exam, and small group interaction in the clinical years, where there would likely be marks given by the consultant or registrar for performance in the wards, making it a more vulnerable space for speaking out. The scenario where a student can educate a lecturer is similar to a scenario where empowered patients can educate doctors, as discussed in 5.3.2.5 (Affirmed patients are empowered to participate in their healthcare).

TB continues with her critique of what is taught:

> I think there definitely needs to be a change in attitude, in the way certain topics are approached. And when we talk about sexual health, we don't talk about the sexual health of individuals who might have different genitals or we don't talk about, the different kind of bodies that are out there, and I really think if that was included, if there was more time spent talking about how to approach someone who doesn't, you know, fit the norm, then and how to make them comfortable, it could go a long way. I mean, when we spoke about the consultation, it wasn't even included, how to approach someone, and make sure that you're using comfortable pronouns, it was just assumed, you know, you walked in and you say, "more meneer" or "more mevrou" (TB, cisgender student).

DL said that the curriculum is quite limited. As a trans person, she has thought deeply about what she would like to see in the curriculum. She describes her need to go beyond definitions to practical aspects such as pronouns in the context of time constraints:

> The first thing we talk about every single time we discuss gender and sexuality, is what's the difference between gender and sex. I know it's important, but because I am so engaged and interested in this topic, it's kind of like, okay, when are we going to progress, to, I don't know, interview questions we can ask, how can we be sensitive, because the difficult thing that I find as a med student, is how do we kind of… ask somebody about their pronouns, understanding that most people are cis, how do we do those things and be sensitive and be time-orientated, because we only have seven minutes per patient, in like this over-burdened health system. That's what it is, suggest a practical approach to engaging with a trans person (DL, transgender student).

HM describes sitting in a lecture where unhelpful terms were used, and realising that they would do things differently:

> I think in second year, we had a discussion, or a lecture with regard to genetic variability when it comes to embryology and all of that. From my knowledge of how the non-binary / transgender community views things, I know that certain terms are not necessarily the most welcome, or seen as helpful towards the community, and a lot of the terms were kind of thrown around in the classroom, umm, by the lecturer. I kind of felt that this may not be helpful to anyone sitting in the lecture hall, or any patient we may be communicating with, may be offended by such terms and in my

> head I was like, so, you're not going to do that in your professional capacity, let me try and correct as much as possible and provide an alternative viewpoint within the medical community, wherever we can (HM, non-binary student).

AA felt that lecturers using very cis-normative language was problematic: "I mean I guess this is just like cisnormativity, a lot of lecturers using very cis-normative language, or just assuming that like all males and all females are cis men and cis women" (AA, transgender student).

L also commented on cisnormativity and pronoun visibility:

> We're taught very cis-normative medicine. Umm, we're never encouraged to ask, as soon as a patient comes in, what are your pronouns, we never, even as healthcare providers, ourselves, tell patients what our pronouns are. So, we don't normalise anything but cis normativity. It's very othering, assuming that we are all cis, we are all straight, umm, Ja, and I think the curriculum can go so much further, into deconstructing that notion, and I think that would be a good place to start. I think when we learn about history taking, we should turn it on its head. I think even by just raising pronoun visibility with our patients, and assuming our patients aren't cis, I think it could open up way more conversation and doors, both for us as healthcare professionals, and for our patients (L, cisgender student).

The students were critical of the curriculum, saying that there are cis-heteronormative assumptions made, and that it does not adequately prepare them with a practical approach to engaging with a TGD person, such as asking about pronouns. There was no evidence that the experienced curriculum included aspects of cultural humility, where one avoids making assumptions about patients (Tervalon & Murray-García, 1998).

There is extensive international literature pointing to the inadequate inclusion of GAHC in curricula, as discussed in the literature review in chapter 2. An ethnographic study described pervasive heteronormativity at a medical school (Murphy, 2014), that resonates with the concerns of the students in this study that heteronormativity and cisnormativity are very prominent. MacKinnon et al (2021) make the observation that "teaching learners about limited pearls of trans health content fails to address pervasive cisnormativity, heteropatriarchy, and other

structural dimensions that characterise learners' broader training experiences" (MacKinnon et al., 2021, p. 199).

This kind of curriculum critique from students is exactly what is needed for curriculum change. The UCT Curriculum Change Framework describes a theory of change with different phases (UCT Curriculum Change Working Group, 2018). The first phase is contestation, where the curriculum is scrutinized for its role and power to marginalize the voiceless and the least powerful. This creates the opportunity for unlearning and repositioning. This is followed by reconstruction of the curriculum and reconstitution, with reflection an ongoing, iterative and a continuous process of looking at what has worked and what can be learnt (UCT Curriculum Change Working Group, 2018).

This framework recommends that:

> Institutional racism, ableism, sexism and heteronormativity need to be addressed with honesty and courage. Racism as a central cultural dimension of colonialism introduced concepts of superiority and inferiority in relation to human beings, with this translating into other forms of difference (UCT Curriculum Change Working Group, 2018, p. 58).

The authors criticise traditional teacher-student relationships which re-enforce hierarchies of power and privilege and recommend a decolonial pedagogy "so that pedagogic relationships are imbued with a consciousness that is inclusive, socially just and constructive" (UCT Curriculum Change Working Group, 2018, p. 58). From a decolonial perspective the critical role of students in meaningful curriculum change is recognised.

In the first two themes, the learning environment and curriculum were discussed from a critical perspective, with students expressing disappointment at how limited the curriculum is in terms of GAHC. In the next section the potential of curriculum will be discussed.

6.3.3 Theme: The potential of curriculum: "revolutionised the way I was thinking about the world".

None of the practitioners reported positive curriculum experiences where GAHC is concerned. Some of the students described positive experiences, including the delight on being given language.

B describes the role the formal curriculum played in his journey of learning about GAHC in research story 5, that it gave him language and revolutionised the way he was thinking.

For L, it was helpful for a friend's journey as a trans woman, that at university they had access to the language: "…the university was also like, now we had access to the language and even to put our feelings in context" (L, cisgender student).

CM described an aspect of the curriculum as positive, where they learnt about the biopsychosocial-spiritual approach:

> This is perhaps something where the curriculum does speak a bit to the issue, it's when we talk about the current concept of what health is, and we employ the biopsychosocial-spiritual model of health, it definitely lays a good framework for saying, okay, you know, I can't just treat my patient's illness, I also want my patient to be comfortable, I also want my patient to not be distressed, I want my patient to feel like a person who is of equal worth to any other person (CM, cisgender student).

The GAHC curriculum proposed by Ellaway et al. (2022), specifically mentions "language and terminology" as a core teaching objective, that includes appropriate terminology in providing patient care, as well as "knowing how to use preferred patient names, pronouns, and language, and how this can increase TGD patient comfort and build positive rapport" (Ellaway et al., 2022, p. 41). It is positive that students in this study did experience the curriculum as giving them language.

In this theme the positive aspects of curriculum were explored, that it gave students access to language about gender diversity, and that learning about human rights influenced how they saw the world. The next theme explores how participants

thought about what could be done, to create a curriculum that will facilitate learning about GAHC.

6.4.4 Theme: Forging gender-affirming practitioners "changing the lens, of how we view our patients."

The practitioners and students had many ideas about how medical education could contribute to students becoming gender-affirming practitioners. The attitudinal aspect is described as the most important.

T strongly feels that students need to understand the "why" of caring for trans patients, rather than the theory, and that this is possible with a personal connection. Some students have not met any trans people and it can be challenging to think about diversity or understand why GAHC is important. T feels it is important to connect with empathy rather than detaching. This is described in research story 1.

D recognises a big need for training to prepare graduates for seeing trans patients, as described in research story 3. She too differentiates between attitude and clinical knowledge. She expects doctors to understand about pronouns, even if they do not have detailed clinical knowledge. One can refer if you do not have the expertise but need the basic understanding to be respectful of the patient and not dismissing their condition as "not a real problem". D also argues that training in GAH needs to be compulsory and not part of an elective.

SM regards the attitude as the most important aspect, that students need to be exposed to early in their training. Regarding qualified professionals, she sees "more ignorance than intolerance" and argues for getting the knowledge out there. She compares learning about GAHC to learning about treatment for HIV, that it was initially not something doctors were confident about.

> I think communication skills, I think those early years of exposure to other people's opinions and ideas and realising that umm as a sort of 19-year-old medical student you don't have all the answers and there's lots of different ways of living. I think that just opening, helping students to open their eyes to all the different ways of living … And then I think the other thing is the assumptions made during training, because those are hugely important, you know right from the start, medical students should be

> learning that there's more than male and female. It's not something that you can do as a little stand-alone module, no, it's got to be all the way. I think that would make a big difference, so those are some of the attitudinal things, really… (SM, cisgender practitioner).

TB argues for an approach that normalises diversity, "to be able to care for each patient that comes in", saying:

> …if students could partner with experts in the field, and have seminars, or actually team together to add to the curriculum, content that helps medical students really understand that diversity is not something that you opt out of, or opt into, it's something that just exists. So, you have to be able to care for each patient that comes in, I mean, it's not really an option, if someone has a specific condition, you can't ignore that because it doesn't suit your world view. Umm, I think that if we had an approach that really normalised all of the diversity issues and all the diverse situations that a doctor can end up in, when it comes to people of diversity in identities, then I think that we would have a lot more options available, for people when they look for treatment (TB, cisgender student).

This is a powerful perspective, that diversity is not something you opt out of, or opt into, that health professionals have to be able to care for each patient they see. This resonates with my approach as a family physician, that we should be able to provide care to any person, regardless of what they present with.

For L, it is about "changing the lens, of how we view our patients". She said:

> If we're going to really open up the doors of gender-affirming healthcare, if we think of it, this is a much larger answer, because if we think about changing the curriculum, or changing the lens, of how we view our patients, how we view the world as not, 'we are all heterosexual, cis heterosexual doctors, and everybody else that we see are cis heterosexual, except this percentage of people, and then they need this, and then we prescribe a level of care that either pathologises them, or takes away their autonomy', I think ya, I think we'd go much further by introducing this concept in first year, when we learn about history taking (L, cisgender student).

In the research journal, I documented: "To change from not seeing the 'pathology' but the human and how they see themselves. This is disruptive work – to challenge

how our professions see people". It is about how we approach and view our patients, as diverse human beings.

Practitioners and students point out that the attitudinal aspect is critical, for students to understand that there are different ways of being and diversity in sexual orientation and gender identity, that assumptions of everyone being heterosexual and cisgender are not accurate. This is why we need to help our students to see people through a different lens, to be able to interact with diverse patients respectfully.

Donald et al (2017) argue that a structural competency approach can be helpful in integrating the health needs of sexual and gender minorities into curricula, to understand that stigma and health disparity are not simply the product of interpersonal encounters but also are the result of structural inequity (Donald et al., 2017). In addition, the GAHC curriculum proposed by Ellaway et al. (2022) mention "History, Epidemiology and Social Determinants of Health" as core teaching objectives (Ellaway et al., 2022). This links to T's argument that students need to understand the "why" of caring for trans patients.

Stroumsa et al (2019) found that provider level of knowledge of TGD health care was associated with transphobia but not with hours of formal or informal education (Stroumsa et al., 2019). The authors suggest that the effectiveness of such training in GAHC may depend not only on increasing informational knowledge, but also on addressing providers' biases, whether conscious or unconscious. They state that:

> Educational initiatives will need to take learners' backgrounds into account, directly address prejudice and enhance cultural humility. These efforts will resonate beyond TGD patients, to improve the readiness of trainees to provide care for a broad array of under-represented minorities and stigmatised populations (Stroumsa et al., 2019, p. 404).

Although the participants in this study did not specifically name cultural humility, it is implied in the descriptions of what participants wish for a curriculum, that it includes training on diversity and fostering an attitude of respect.

McPhail and colleagues (2016) argue that “while addressing gaps in knowledge about trans health through medical education is important, only through addressing the internalized transphobia of learners will medical education about trans health be truly effective” (McPhail et al., 2016, p. e71). Beagan et al. (2015) state that education on GAHC cannot merely focus on facts about hormone values or surgical after-care and insist that it has to address student attitudes and perceptions (Beagan et al., 2015). This view aligns with what participants in this study emphasised, that the attitudinal aspect is the most important.

In this section on participant views on how to “forge gender-affirming practitioners”, the attitudinal aspect was emphasised. A practitioner can read up on the detail or can refer as D pointed out. The basic gender-affirming approach of respect for diversity, empathy and awareness of pronouns is key. This should take into account learners’ backgrounds and potential prejudice. From a PIF perspective, attitudes form part of what a student brings with them to medical school, and this can be challenged through reflection.

In the next section, the importance of including the voices of TGD people will be explored.

6.3.5 Theme: “The voices of the affected need to be heard.”

T emphasises the importance of including “the voices of the affected”, in general listening to patient voices, but specifically when developing training in GAHC. She argues that we need to be talking to the people and not about the people:

> When you’re having any discussion about a group of people who are marginalized, their voices need to be heard. Now, you can’t have a round table on abortion and reproductive rights and not have women at that table, and I think it’s the same with LGBTIQA folk, and I think it’s the same with trans folk, like, the voices of people in that community need to be heard (T, transgender practitioner).

She describes listening to patient voices as a powerful tool in preventing the erosion of empathy:

> And no-one like ever listens to the patient’s voice. You know they have the tutorials and ward rounds, but the doctor is telling you about the patient, no-one ever listens

> to the patient's experience. It could be such a powerful tool, to stop you from going down that road of like, dehumanizing and cutting yourself off from empathy. You know, we interact in these circles, where the patients are like our study material and our test subjects, they just never have a voice (T, transgender practitioner).

K reflects on decolonisation of GAHC and asks how we can empower patient voices, as it can help healthcare workers realise, "it's just a person, like I am a person".

> So, if we think about the whole idea of the decolonisation of gender-affirming healthcare, and the whole idea of, how do we do it differently? And what is our possibilities and opportunities in South Africa to do it differently than for example the global north? How do we really as South Africans, as people from Africa, bring a new narrative into gender-affirming healthcare where it becomes much more a kind of ubuntu, much more a kind of a becoming entrenched in our community on the one side, and that it becomes just one of the various kinds of healthcare people can receive, so that it does not become this kind of 'this is a new thing, let's all look at it, or let's fight for it', but that it becomes part of healthcare as one of the aspects. But also, how do we make it more decolonial in the sense of where the the patient becomes more empowered to have a voice in their healthcare (K, transgender practitioner).

K tells of an example of a doctor not listening to a patient regarding their experience with specific medication and reflects, "it is about us being in our bodies and having certain knowledges, and if we can just start interacting with our doctors in that way…" (K, transgender practitioner). This is K speaking as a trans person "about us being in our bodies" rather than as a health professional.

For patient voices to be heard, health professionals need to be open to listening:

> I think the responsibility is first with the person that created the mess-up of the system, and that would be the healthcare provider. If the healthcare provider can deconstruct the healthcare environment, and then rebuild it into a safe space, the patient doesn't even need to be very courageous. Sure, they need to step into that space, that's true, but the invitation needs to be there, from the healthcare provider (K, transgender practitioner).

This is a wonderfully disruptive perspective, for a health professional to deconstruct the healthcare environment and rebuild it into a safe space. This has to do with a change in the power dynamic in the consultation, to allow the patient voice to be heard.

N describes interaction with trans people as a valuable aspect of training health professionals:

> I think that it differs from person to person, but when you interact in a space where there are practitioners as well as participants, who are trans people, then those interactions actually build more information and interactions for people to see that from looks you cannot judge people. Because until someone tells you I am a trans female, you may never know, or a trans male, you may never know (N, cisgender practitioner).

CM believes in the value of people telling their stories:

> I'm very strongly of the opinion that the way this kind of problem gets solved is by, people telling stories, because you know, it's a lot more difficult for someone to say, that, you know, being transgender or being gay is a choice, if their friend, their best friend who they have known their whole lives, says to them, I'm actually, whatever, and I tried for this long not to be this, and I almost ended up harming myself, because of it, and finally I have accepted it and it is just not a choice, and this is just how I am. And now obviously you get the people who are like, who will just drop ten years of friendship, and the parents who will kick their children out onto the street, umm, which is deplorable, but then you also get the people who listen and then, and have a small change, and then over time gradually progress… (CM, cisgender student).

Also:

> …the same with homophobia and transphobia, so if people would just humble themselves a bit, to listen to other people's stories, and start believing other people's stories, that's probably how you start fixing it. And I think that's easily implemented in a medical field, there are gay doctors, there are transgender doctors, umm, get them to come and talk about it, and give a lecture about it (CM, cisgender student).

K also emphasised the value of stories:

> I think in the end the use of stories is amazing when you train. And a story does not always need to be told by the person themselves, being physically there. I mean by using videos, by even reading the narrative, can be very wonderful already, but I have found, the possibility to engage with a trans person, usually is quite significant for a lot of people. It is for me broader than just training let's say in gender diversity, if one maybe talks about cancer and you can have a cancer survivor there, if you can have people talking about their depression or schizophrenia. It has a very empowering factor for the person telling, but it also breaks down the barriers for the healthcare workers, because once they again realise, it's just a person, like I am a person. So, it's again that kind of community-building, and I think again a very interesting way of doing participatory work and decolonisation work, is to start bringing in the voices of our community. Because maybe we would even be more human-orientated than disease-orientated if we do that (K, transgender practitioner).

This is the humanity that I would like to see in medical education, that students can learn that a patient is just a person like they are. Having a human-oriented rather than a disease-oriented approach.

In the medical educator group discussion, the importance of the trans community having a voice was discussed:

> The education system and health system are quite interrelated, and the community leadership also, and maybe our perspective to look beyond patients and see them as fellow community members, and I think about civil society maybe having more of an active voice, in how curricula, or the education system and the health system interrelate. And I think especially if we have community members and champions on trans health issues in the driving seat as part of instructional design & curriculum review through co-design, and collaboration.

A participant who is a gynaecologist reflected on the importance of engaging with the trans community about what should be taught, while being mindful that there are potential complexities with direct student interaction with trans patients:

> One thing I wanted to add from a clinical perspective, is really engaging with the transgender community, on what they would like us to learn. And get people there who are happy to talk, because if you're going to put students more on the clinical platform, umm, they're not going to, certainly I wouldn't be putting them with my trans patients, because already I'm very conscious of how they are feeling, in a woman's

> clinic. You know when they are trans men, I normally see them on my own, on a day where there are no other patients there. So, it's not necessarily putting the students around that person, who may not want to be seen as a teaching topic. So, I think that you need to find some organisations, engage with the trans community, on what they would like, and if there are people who are willing, because you also don't want to create the scenario where students bombard someone who is not ready to be bombarded, so we're not teaching them mindfulness then at all.

Where she talks about a patient "who may not want to be seen as a teaching topic", it has echoes of research story 2, where E felt like he was not a human but an exam question.

Another group participant agreed with this complexity, saying "I find it really hard to have people in the classroom, talking about their experiences because it often has an edge that is often quite uncomfortable". This creates a tension, with the ideal of including patient voices not always easy to implement.

In PIF, clinical experience has been shown to impact on the socialisation towards professional identities (Holden et al., 2012). In the recently developed TGD curriculum framework, the inclusion of TGD community members in training activities is emphasized (Ellaway et al., 2022). This has been demonstrated at the University of Louisville, Kentucky, USA, where community engagement resulted in curriculum changes such as teaching about heteronormative and cisnormative bias in communication (Noonan et al., 2018). In a WHO publication on Transgender health in medical education, involvement of community members in the development and evaluation of GAHC curricula is identified as key (Hana et al., 2021).

Sharma (2018) argues that meaningful patient involvement in curricula can be considered an act of decolonisation. She cautions about the way in which patient voices are included. It could perpetuate colonial ways of knowing and representing the 'other' if there is no recognition by medical providers of their privilege and how practitioners have marginalised those voices to begin with (Sharma, 2018).

A qualitative study in New Zealand on teaching about transgender healthcare explored the complexity of including TGD community members in teaching which includes direct interaction with students (Treharne et al., 2021). This study found that not all TGD people want to be involved with student teaching, and that it may be uncomfortable for those who do get involved. The issue of safety of community members was raised, if for example there would be overt discrimination from students (Treharne et al., 2021). This resonates with the discussion in the medical educator group, that direct interaction with students may be uncomfortable for a TGD community member.

In my experience it has not been easy to find TGD people who are willing to share their experiences in person. I have used video recordings and the reading of narratives in training on GAHC, as it is important to bring in the voices of TGD people. I have observed that many TGD people do not want to be activists and visible in society as being trans, some prefer blending in with society and just living their lives as any cisgender person would.

In summary for this theme, it is important to include the voices of TGD people when planning curriculum and training on GAHC. The stories of patients can be powerful, not just for GAHC but more broadly as well. There are different ways of doing this, such as reading a narrative, using video, and inviting people to speak. Caution was expressed regarding direct interaction between students and patients, as not all patients are comfortable talking about their experiences. The focus will now shift to two other important components of PIF, namely reflective practice and role models.

6.3.6 Theme: Reflection "how to give a damn about people with experiences different to your own, that only comes out when you do some introspection and reflection".

Reflection as a means of incorporating GAHC into the curriculum was emphasised by several participants. Orsmond et al. (2022) similarly consider reflection to be a key component of PIF.

T argues that student introspection and reflection about values and own prejudice can facilitate "unlearning" and rethinking one's position. She compares this with

teaching about termination of pregnancy (TOP), giving students tools to understand and make their own decisions. She describes students as being on a spectrum, with some social justice inclined and well informed, others with "casual prejudice" and those with extreme views. For students in the "undecided middle", she feels that they can be brought to a space of reflection, to look at the way that they act, through their own ethical lens, and question themselves, "do I agree with what I'm doing?"

> And I think the best way to disarm and minimize transphobia is through education, because a lot of it is just informed by ignorance. People have not sat down and thought about the issue, and said, "well, how do I feel about this?" And I think that definitely there are some right-wing extremists that you are never going to convince. You know it's the same argument for reproductive rights, but if you just teach it, and give people the tools to understand, and to make their own decisions, I think you can drive tremendous change … So, I think the challenge is in shaping medical education in a way that addresses it effectively and that does it within a space that is kind of very like results orientated and very outcomes focused, and you know getting people to care about, because it's not stuff you can teach from a textbook, how to give a damn about people with experiences different to your own. That only comes out when you do some introspection and reflection, and examining your own values and where they came from and how you interact with people, it's got to be like this active process, you know I often use the word 'unlearning'. The first thing you have to do is unlearn all the toxic stuff, and all of the harmful information, and then get people to a point where they will look inside themselves and figure out what they actually believe in and what's in line with their values (T, transgender practitioner).

In research story 1, there is the inner dialogue about how T views herself, that is an aspect of her own identity formation. Here she talks about students looking inside themselves to figure out what their values are, which can be a significant part of their PIF as gender-affirming practitioners.

K sees training as helpful for reflecting on self and own identity. Transphobia can be addressed with training, taking the fear away and understanding more about diversity. Understanding what gender-affirming entails can enable practitioners to work respectfully with people who are different from them.

> Basically to reflect, but also on self and own identity, positioning of self in the end as also the carer, or the practitioner, I think it's a fantastic way of also engaging with

> your own identity and understanding, and your understanding within the world, umm, so I think it can even be beneficial for the practitioner, for themselves, in personal development, but then also to have an understanding to the broader context, and to become a very skilful practitioner …The other side is if one looks at gender-affirming practice as such, I think a lot of people do not have a clue what they do, and the next minute they are confronted with the gender diverse person walking in and quite often if we deal with the unknown, instead of embracing it we tend to either run away or become more confrontational. I think a lot of times transphobia starts playing a role within healthcare whereas it could be very different if a person has already been trained in it and has already thought through it and has become aware that there is diversity in the world and I'm going to see many diverse people, and that working from an affirming perspective, it is ethical (K, transgender practitioner).

Here K refers to professionals in practice, who have not been exposed to gender diversity and therefore feel out of their depth and respond with fear. This is contrasted with professionals who have been trained in GAHC and have reflected about diversity, who can work from an affirming perspective.

E argues for critical reflexive practice as a foundation which can prepare students for thinking about GAHC:

> A critical reflexive practice needs to be part of any training where human work is involved; I think. It is a practice that needs to be built up and encouraged. Imagine, if you have your second- or third-year med school students, that they start at the start of the year, they do a critical reflexive course, and then at the end of each module or whatever there is a reflexive component. So, when you get to gender-affirming healthcare, you can facilitate reflection on the various issues, so that people start practicing it. Because it's a skill (E, transgender practitioner).

In the medical educator group discussion, critical thinking and reflection were emphasised as well:

> We also have to remember that the medical students often have taken biology and science in school, they haven't taken History or subjects that would be developing critical thinking. So, we're starting at quite a science-based thinking framework, many of their colleagues in other university departments might be starting with a stronger critical thinking base.

> So, I think it's got to do with a whole lot more of the emotional intelligence factors, and I do really believe that we should encourage reflection. You do learn through reflection, that is how we grow, that is part of adult learning, umm and thus encouraging reflection, even if it is going out to cycle or whether it is to write a piece or to write a poem, we should definitely be teaching that to our undergrads as a form of development.

One of the group participants spoke about witnessing as a model to encourage reflection:

> I teach a lot around witnessing, Weingarten has a model, on witnessing, how we witness both micro-aggressions and aggression, but also witness suffering and witness our own engagement and our own experience with suffering. I think there is a lot there, that helps us to place some of this from a generic perspective, so micro-aggression happens to so many different identities, and helping students process micro-aggression, and think, how that relates to their professional identity, and how their own mis-engagement, misaligned engagement with patients, can lead to unethical practice.

Another participant reflected on his own learning with reflective discussions:

> One of the things that we may need to rethink, redesign, is the spaces outside of formal teaching. Umm, if I think back, the biggest impacts in my learning journey, was the moments that I had an opportunity to have reflective discussions with registrars, with consultants, outside of formal academic spaces, that shaped me, and shaped the way that I think about patients, that was extremely powerful, that I remember as if it happened yesterday. So, maybe the answer doesn't lie in formal teaching or adding more to the teaching of medicine, but more in creating spaces around the teaching, that allows for discussion, reflection, building awareness, resilience, tolerance.

This refers to the more informal aspects of curriculum, or HC (Hafferty, 1998; Martimianakis & Hafferty, 2016), that can have a significant influence on PIF.

The concepts of reflection and critical consciousness are closely related in the medical education literature. Critical consciousness (Freire, 1970) is a useful

construct for medical education, to foster awareness of professional power and patient-centered practices through reflection (Manca et al., 2020).

It is essential for clinicians and students to critically reflect on their own situatedness within structures (Thomas et al., 2020). Bleakley (2017) argues:

> Raising students' critical consciousness will allow them to sensitively gauge the positions of others and to engage in dialogue to address issues such as inequality and inequity so that previously silent and silenced voices can be heard (Bleakley, 2017, p. 289).

This resonates with what T and K said about the need for reflection on one's own values and prejudice in order to "unlearn" and gain a deeper understanding of gender diversity.

Reflection is considered a key factor in PIF (Orsmond et al., 2022). When students are explicitly encouraged to reflect on their experiences, they become active participants in the formation of their own identity (Cruess et al., 2015). Wald (2015) describes that guided reflection both as an individual and in a group, can support students to engage as active participants in their PIF (Wald, 2015b).

The ways in which reflection in medical education is practiced, have been criticised (de la Croix & Veen, 2018; Naidu & Kumagai, 2016). Students may write what they think educators may want to read (de la Croix & Veen, 2018). Naidu and Kumagai (2016) contrast the Western emphasis of individual reflection with collaborative reflective practice in non-Western contexts (Naidu & Kumagai, 2016). It is important from a decolonising perspective, to take such criticism seriously. For the PIF of a gender-affirming practitioner specifically, participants in this study described reflection as an individual process (e.g., reflective writing, cycling, writing a poem) as well as a relational process, in a facilitated discussion (teaching environment), and in a community of practice with registrars and consultants.

In the document analysis that is described in 6.4.6, critical thinking and reflection are mentioned as learning outcomes in documents from both universities A and B.

Reflection about gender identity and prejudice, including looking at one's own values (self-reflexivity), is seen as an important aspect of becoming gender-affirming. The next section will look at role models as a component of PIF.

6.3.7 Theme: Role models "it isn't just enough to have a curriculum that actually deals with this when we as educators, are not role modelling this".

Role models were mentioned as another important aspect of bringing gender-affirming care into the curriculum. A student described how lecturers can be powerful role models. In the medical educator group discussion, the dilemma was discussed of negative role models, and that educators are not all equipped to role model affirming care. In research story 4, JL experienced the ENT professor definitely not as a positive role model.

For student J, lecturers can be powerful role models:

> We need to see it in the people that we are exposed to, like I am sure that most of our lecturers offer really inclusive healthcare, but we're not seeing it. Because coming from like a student society point of view, it's just like, the […] Society doing their thing, but if it's made for everyone, like a lecturer just saying, dropping small pearls of wisdom, I just think that is so important… I think, because I know there's like the med students actually revere the lecturers, they're the end-all and be-all, these doctors who've made it, I just think if it comes from them, I don't know maybe in case study examples in class are just like, telling us stories, of their like, real life experience with non-binary or like on the spectrum patients, students could just see that, wow, like, it's normal, it's something they have to like go through, if I want to be like them, I guess I have to shape myself like this as well (J, cisgender student).

SM expressed the need for a new mindset and attitude in medical educators, to be affirming: "…and of course, what you build into it [curriculum] is a completely new mindset and attitude in every single doctor and educator that a student comes into contact with!" (SM, cisgender practitioner).

Role models were discussed in the medical educator group discussion, reflecting on the research stories shared prior to the discussion:

> Because I was also looking at how in many cases the role models were actually not good role models. And actually, caused psychological harm and other negative effects.

Also:

> …and it is a lot of the way that we are dealing with issues like this [GAHC], are unfortunately things that have more got to do with role modelling, and you can see in the narratives that we read, what an impact that had on everybody, whether it was a psychologist or whether it was the medical students.

The challenge of bringing in "soft skills" and affirming care into the curriculum, without educators who role model this was discussed: "In the sense that, is it, when you say it's a soft skill, and when those, the educators themselves don't have those soft skills, how do you then transfer those skills?"

> Because I really do feel the issue of a role model, it isn't just enough to have a curriculum that actually deals with this when we as educators, are not role modelling this. We are still stuck in our own old ways so it actually wouldn't make any difference.

One of the participants reflected on role models in undergraduate training, that can inspire students.

> So, anybody that students look up to, they have a huge impact, and shouldn't we be targeting faculty instead of students? I think in an ideal world you would want all of the people who are teaching your students to be talking about the same value system, bringing in those softer skills, umm but I think the reality that we are all faced with, is that it's just not going to happen. You are not going to get a lot of the people who work in our hospital, behind something like this.

This led to a discussion of resilience when students face negative role modelling:

> So, I think we actually need to be upfront with students, because we can't change all the educators, umm, and give them permission to still hold on to that idealism and that way of behaving that they want, even if they are seeing bad behaviour. You know, they can report bad behaviour, whatever, but we know from long experience, that we can't change the 'dyed in the wool' ones. They are terrified, and it takes a

> very brave student to speak up. I don't think we should expect that of them in this setting, but we can encourage them to report and to hold onto their ideals. And I think part of what we need to do, is enable our students to be resilient in the face of that kind of behaviour [referring to misgendering]. Umm, because they are the young, idealistic ones who are coming through, umm and they're going to see bad behaviour, they are going to see practices that are really unacceptable and that power dynamic is difficult to navigate and I wouldn't expect a student to navigate that, in that space, but I do think that we can, you know those of us who are the so-called "converted", we can talk openly about the fact that you are going to see bad examples, and you know you get to decide what kind of doctor or practitioner you want to be. You know, now is your moment to do that. So, just allowing the students the space to feel uncomfortable with what they have seen and knowing for themselves that they are going to do better when they qualify.

This participant contrasts negative role models with lecturers who are affirming, and who can create spaces for students to reflect on what they have seen.

One participant expressed hope that things are changing:

> Remember, twenty years ago, we were the students on campus, so a lot of us talking here, were actually either just qualified or the ones in medical school and look where we are now. So, a change will occur, we don't want it to take twenty years, but let's get our students to stand on our shoulders. Let's keep the positive role models, let's ensure that there's a golden thread, that they can follow through. Let's keep on driving the topic, because the more we create awareness, the more champions will stand up, the more it will become a conversational point and the easier it is going to be to expose students to people who are role modelling the correct behaviour.

Another participant responded by talking about the importance of leadership to change the culture:

> If there's a, almost like a mandate, or a championship from a high level, and a buy-in from the leadership, whether that will also help to change the culture, because as was said, twenty years ago, we were the students, so surely there must be people who are now in positions where they could also help influence the culture or change the culture within an organisation.

This was an important moment in the discussion, with participants being aware of their own potential role as leaders who can have influence.

Role modelling is identified as an important factor that impacts on PIF (Koh et al., 2023). It is also seen as a component of the HC, that needs to be discussed with medical students in order to “to provide students with the appropriate reflective tools to interpret the negatives of the hidden curriculum in a constructive and beneficial fashion” (Brown et al., 2020, p. 1117). Qualitative research has described that negative role modelling practices can inhibit PIF (Findyartini et al., 2022; Silveira et al., 2019). This resonates with research story 4, where the student describes an upsetting experience with an ENT professor. This can be seen as part of a HC that undermines the intended/espoused curriculum.

Wald (2015) emphasises the importance of fostering resilience in medical students, as they must reconcile dissonance between the stated values of the medical profession and the realities of medicine as practiced in the real world (Wald, 2015a). This was pointed out in the medical educator discussion as well.

Although negative role modelling is inevitable, medical students can learn from the experiences and obtain a positive impact through self-reflection (Findyartini et al., 2022; Sternszus & Cruess, 2016). Medical students make a judgment on a role model’s behaviour, which can include a judgement on “how not to behave” (Passi & Johnson, 2016, p. 704). This is similar to the student experiences described earlier (Chapter 5, theme 5.3.3.3), where they learnt form negative situations what was not affirming practice. This relates to transformative learning, where a “disorientating dilemma” can result in reflection that facilitates PIF (Van Schalkwyk et al., 2019).

Hana et al (2021) found that “A common barrier to teaching transgender health is lack of topic-specific competency among medical school teaching staff” and identified staff training as a key component for a successful GAHC curriculum (Hana et al., 2021, p. 299). In their WHO report, they recommend training of existing teaching staff in gender diversity and transgender health, by introducing modules on GAHC into continuing professional development programmes, as well as in

postgraduate curricula (Hana et al., 2021). In the medical educator discussion, training of educators was emphasised as well.

In conclusion for this section, role modelling is an important component of PIF, and currently there are few gender-affirming role models. Hence the need to equip students to be resilient in the face of negative role modelling, as well as the training of educators. The next theme will explore ideas of how GAHC can be integrated into the curriculum.

6.3.8 Theme: Timing in curriculum and integration “formally incorporated in the preclinical or the junior years, and then followed through a spiral into the senior years”.

Two of the practitioners were very vocal about inclusion of GAHC early in the curriculum. In the medical educator group discussion, although there were initially different views on the timing, later in the discussion there was agreement on a spiral approach. Integration of GAHC in the curriculum as opposed to a separate module or a silo approach was emphasised by a practitioner and two students, as well as in the medical educator discussion.

N feels strongly that GAHC should come early in the curriculum, and form part of learning the language of medicine, knowing how to address people, and knowing there are people who do not want to be boxed.

> I believe, from first year, it should be there, you know from primary healthcare, from health policy, just teach everyone, nursing care, pharmacy and everywhere that gender-affirming healthcare is for everyone and its everywhere, so that people start getting used to knowing that not everything is black and white … and the earlier you introduce it, even in medical school, because we have a lot of medical students who commit suicide because they themselves need gender-affirming care … The sooner it just gets into the curriculum, the earlier, the better, that by the time they do clinical rounds, they know in the ward there is a space for gender-affirming healthcare, then they start to know by just asking someone, how do you want me to address you? That is enough greeting to respect someone’s dignity … I really believe that gender-affirming medicine can start from first and second year of medicine, when we learn medical terminology. To grow up with it, so that when you clerk patients, including knowing how to address people, learning to respect, you know when they said

> respect for autonomy, the rights of people, gender justice and everything, so that your mind is conditioned to know that there are people who do not want to be boxed, and also when it happens like that, the hospitals will now start to realise that rest rooms, wards, need to accommodate everyone (N, cisgender practitioner).

This is a wonderful insight, that GAHC teaching is relevant for all health professionals, and should be introduced early, when learning medical terminology and how to greet patients. N also emphasises the importance of learning that "there are people who do not want to be boxed", learning about diversity. She sees the potential that such medical education can impact on health facilities too, to realise that their rest rooms and wards need to be inclusive.

SM said that students should learn about diversity from early in their medical training:

> And then I think the other thing is the assumptions made during training, because those are hugely important, you know right from the start, medical students should be learning that there's more than male and female … I think communication skills, I think those early years of exposure to other people's opinions and ideas and realising that umm as a sort of 19-year-old medical student you don't have all the answers and there's lots of different ways of living, which is done here. I think that just opening, helping students to open their eyes to all the different ways of living (SM, cisgender practitioner).

E feels strongly that GAHC should not be something separate in the curriculum but integrated:

> Bringing it [GAHC] in implies that it is an add-on, which singles it out as "different" – what I would really want is for gender difference (and all other "differences") to be part of the regular discourse – in academia and elsewhere. When we take the add-on approach – where you'll have a gender module, for example – you centre gender as the main problem, and if that's the way you view all transgender patients, you're always going to have that as a central epistemological assumption, and you're going to struggle to view them as whole people, who have all the regular issues, which may or may not include stuff related to their gender (E, transgender practitioner).

B argues for integrating GAHC instead of it being a separate module:

> So, I think it would be so meaningful if there were threads, I think now it's more like points, if it was a thread that carried out, and people thought more… You know, now people come in and they're like, okay, we're doing the queer thing now, or we're having the LGBTIQ session, everyone can just sleep. You know it's for DP [due performance], but I'll just write a reflection, whatever, but I think if it was given the same sort of weighting as anatomy, physiology, because it's part of what makes you a safe doctor, right? If one day someone comes to you, and you can't pick up that they are in distress for these particular reasons, you would have failed that person (B, cisgender student).

B recognises the importance for medical students to learn about LGBTIQ health, that is part of what makes you a safe doctor. A safe doctor would be able to treat diverse patients and not miss something important because they are ignorant.

DL argues against teaching trans issues in a silo:

> Trans issues are taught in a silo, in this, trans people and gender-affirming healthcare is this single thing, and the LGBTIQ+ community is a single thing, and we don't kind of incorporate it in other spheres, I know we're talking about gender-affirming healthcare, but just in other spheres, we also don't engage with it (DL, transgender student).

This is a powerful reflection from a transgender student, that GAHC should be integrated as TGD people present with other health conditions as well. This was also explored in the theme 5.2.2 Affirming in every space in Chapter 5, that a gender-affirming approach is relevant in all contexts.

In the health educator group discussion, there were different views on the best time to introduce GAHC. Some participants felt that it should come early in the curriculum. Others were concerned that students in the preclinical years may not have the clinical context to make sense of GAHC:

> So, I think we have a real disjuncture, and it's difficult to say that we should push this down into the preclinical years, where students don't really know how to place it, umm, and they're so worried about learning the disease and science, that they're not able to prioritise the psychosocial. Sorry, umm, to be so critical.

After some discussion, the agreed view was a spiral approach, with introduction in the preclinical years and revisited later:

> Students in the preclinical years, might not necessarily engage because they don't have the substrate to work with, they're not seeing patients yet, umm, and, so I don't think that this kind of topic can, we'll just give it to preclinical, they can do it there because that's where they do all the 'hopes, fears and beliefs' fluffy stuff, I think it has to be formally incorporated in the preclinical or the junior years, and then followed through in a spiral into the senior years. I think they need the foundation in preclinical years, but by the time they get to the clinical years, it has to re-appear. It needs to be designated and formalised if it's actually going to make a difference to the graduating cohorts.

This participant points out the value of spiralling topics through the curriculum, based on her own experience as a medical educator.

> I think it has to be formally incorporated in the preclinical or the junior years, and then followed through spiral into the senior years, and I've seen, there's two topics that we teach the junior students which we revisit, and that is sexual and gender minorities, and the other one is intimate partner violence. And I see there's a very definite growth process that happens in the students.

In the medical educator group discussion, integration was emphasized, viewing the curriculum as a system. It was suggested that a golden thread should spiral from the preclinical to the clinical years.

> I think it's not about integrating a few topics within the curriculum. We've got to look at the curriculum as a system, and the medical education process and the discipline as a system. I think it's a much bigger process of building critical thinking, and patient centred care, focusing on progressive spaces, and it needs to be integrated right across.
>
> We really need to be much more mindful, about what is in the golden thread, those aspects of emotional intelligence, what are we threading through those processes? And how can we create models and language that can be drawn between the preclinical and the clinical years, so that a family medicine specialist knows a particular model was used in second year and is able to then reflect on that. So that

we really work this golden thread across, with models that we can all use and draw on.

This is a relevant point on curriculum, that the curriculum is integrated in such a manner that educators in different years know what has been taught elsewhere. This will not happen with a silo approach.

What emerged from both the narratives interviews and medical educator discussion, is the importance of early exposure in the curriculum as well as integration of GAHC in the curriculum as opposed to a separate module or a silo approach.

MacKinnon et al (2021) use the analogy of an island to describe isolated training on GAHC and argue for integration into the curriculum, to encourage students "to bridge 'trans' knowledge across the continent of primary care practice landscapes" (MacKinnon et al., 2021, p. 200). This echoes B's comment that GAHC needs to be a thread rather than just points in the curriculum.

Dubin et al (2018) describe one-time GAHC educational interventions as "a ubiquitous setback to pedagogical efficacy" and conclude that the existing literature supports a shift toward pedagogical interventions that are longitudinally integrated and clinical skills based (Dubin et al., 2018, p. 379). The recently developed TGD curriculum framework recommends that TGD content and experiences should be woven into the general medical school curriculum as well as targeted in TGD educational sessions (Ellaway et al., 2022). Integration in a longitudinal manner was a key recommendation of the WHO publication on Transgender health in medical education as well (Hana et al., 2021). It aligns with the integrated approach that this study's participants advocated.

In this theme, early inclusion of GAHC in terms of the language and how to address patients was emphasised. An integrated approach with a spiral through the years is recommended by participants as well as supported by the literature.

6.4 Document analysis

When one reads the HPCSA documents as well as curriculum and broader Faculty of Health Sciences documents at university A and B, there is a clear intention to teach respect for diversity and human rights, as well as pay attention to the PIF of medical students. Both universities have specific courses providing a basic introduction to gender diversity. This document analysis focused on high level documents, with some module content where I could access it. As I was not able to access documents related to assessment, I am not able to comment on the extent to which GAHC is assessed.

In order to maintain confidentiality of the institutions, documents will be referred to as originating from university A and B, presented in the4 below. This also implies that I am not able to name specific course names, as that will identify the institution.

Table 5: Documents for document analysis

	Documents selected	Document reference in text
HPCSA	Core competencies for undergraduate students in clinical associate, dentistry and medical teaching and learning programmes in South Africa (Health Professions Council of South Africa, 2011)	HPCSA Core competencies
HPCSA	Guidelines for good practice in the healthcare professions: General Ethical Guidelines for the Healthcare Professions (Health Professions Council of South Africa, 2016b)	HPCSA Ethical Guidelines
A	Transformation framework	University A document 1
A	Core learning and clinical skills for the MBChB programme 2007	University A document 2
A	HPCSA 2019 Self-assessment report	University A document 3
A	Accreditation report May 2020	University A document 4
A	Course content, MBChB II	University A document 5
A	Course content, MBChB II	University A document 6
A	Course content, MBChB III	University A document 7
B	HPCSA Self-assessment Questionnaire 2017	University B document 1
B	HPCSA Self-assessment Questionnaire 2019	University B document 2
B	Communication skills Course content MBChB II	University B document 3
B	Course content MBChB II	University B document 4
B	Course content MBChB III	University B document 5
B	Study Guide MBChB IV	University B document 6
B	Study Guide MBChB V	University B document 7
B	Course content MBChB I	University B document 8
B	Faculty Charter	University B document 9

I searched for content relevant to PIF and professionalism based on the literature. In addition, I specifically looked for references to GAHC in line with the second objective of this study (To illuminate how medical curriculum change could enable gender-affirming professional identity formation) and will discuss this first.

6.4.1 Document analysis: GAHC

Specific reference to GAHC is rather limited in the document review. "Transgender Health needs" is mentioned under Obstetrics and Gynaecology, in University A document 3. Course content included "What is 'gender'? And how do gender roles, gender identities, and gender expressions influence our personal and professional lives and practices and our access to health care?" in University A document 5. Readings on transgender are included in University A document 6's reading list. A course content document for university B, includes a learning outcome: "Describe the concept of gender/sexual fluidity and your relationship to it". It is stated that "Inclusion of content on gender fluidity was informed by student feedback" (University B document 4).

6.4.2 Document analysis: PIF and professionalism

In the documents reviewed, professionalism was often mentioned. In curriculum documents for both universities, there is clearly the intension to emphasise professionalism. PIF is specifically mentioned in University B documents 6 and 8. In the former, an end of rotation interview forms part of the assessment, and it states: "We are looking for evidence of your professional identity development, and how this will impact future practice". In document 8, there is a theme "Professional Identity and development" with outcomes that include "reflect the characteristics and responsibilities associated with professionalism" and "explain the potential tension between your personal freedom and professional behaviour as a health scientist".

6.4.3 Document analysis: Attitude of Patient-centred care and empathy

The HPCSA documents are clear on what is expected from medical graduates in terms of compassionate, empathic, and patient-centred care, as demonstrated here:

> 2.1.1(c) Establish positive therapeutic relationships with patients/patients and their families characterised by understanding, trust, respect, honesty, integrity, and empathy" (Health Professions Council of South Africa, 2011).

The university curriculum documents of both universities mention patient-centred care:

> Students learn interpersonal skills, including being non-judgemental, empathetic…

> The focus is on the interaction and communication with the patient, the cultivation of the correct patient-centred, problem-oriented approach (University A document 3).
>
> Our curriculum will place the patient in the centre, and promote family centred, ethical practice. A relationship-based model of care will promote partnership and value-added dialogue towards building meaningful relationships" (University B document 2).

6.4.4 Document analysis: Respect for diversity

The HPCSA Ethical Guidelines outline respect for diversity, and that personal beliefs should not prejudice their patient's healthcare.

> "2.3.10 Tolerance: Health care practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions".
> "5.1.5 Make sure that their personal beliefs do not prejudice their patients' healthcare. Beliefs that might prejudice care relate to patients' race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability" (Health Professions Council of South Africa, 2016b).

Both universities' documents mention diversity and/or inclusivity in terms of values as well as course content.

"FHS will create an inclusive teaching, learning and research environment for gender and sexual diversities and the people with disabilities" (University A document 1).

> "As a faculty, we commit to:
> • Celebrating all forms of diversity on our campuses, including, but not limited to, ability, sexuality, gender, origin, language, race, culture and belief system" (University B document 9).
>
> "Health professionals need to be consciously inclusive in their language (e.g. asking about life partner rather than husband) and attitudes" (University A document 7 - course content in MBChB III).

The rich cultural, racial, and ethnic diversity of South Africa, including the increase in global population diversity compels medical practitioners and physicians to be trained in how to skilfully and respectfully negotiate the implications of diversity in their clinical training and eventually practice (University B document 8).

6.4.5 Document analysis: Human rights, social justice, equity

The HPCSA documents are written with a human rights perspective.

The HPCSA core competencies include:

> 5.2.1 (b) Identify vulnerable or marginalised populations and respond appropriately, with a commitment to equity through access to care and equal opportunities.
> 5.2.1 (f) Apply the ethical and professional principles inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism, appreciating the possibility of conflict inherent in the role of *health advocate*" (Health Professions Council of South Africa, 2011).

A human rights approach and awareness of power relationships and privilege are visible in the policy documents and teaching content of both universities.

Here are some extracts relating to human rights, social justice, and equity:

> We will fulfil our mandate by understanding how power [governed by leadership and representation], knowledge and identity contribute to maintain the status quo of the Faculty. We will challenge intersectional forms of oppression such as patriarchy, privilege, "whiteness", ableism, heteronormativity, Eurocentricity, and Judeo-Christianity, as examples, and in so doing, recognise and create spaces for all voices and perspectives (University A document 1).

> Non-Discrimination: The historically marginalised: womxn, black people, the LGBTQIA+ community, people with disabilities, certain professional disciplines, and Africans will be equally represented and valued (University A document 1).

> As people, and as professionals, we need to be aware of the impact of power and privilege on ourselves, on our communities, on our professions, and on our abilities to provide health care and assist in the healing of others (University A document 5).

> Outcomes include: describe the importance of identifying asymmetrical power relations and how privilege operates (University B document 4).

> We commit to:
> Cultivating empowering environments in which individuals are able to express themselves freely, while considering and respecting the rights and freedoms of others.
> Protecting the human rights of all our stakeholders and striving to ensure a positive impact on the communities we serve.
> We pledge to be advocates for our patients' rights and well-being (University B document 9).

I have demonstrated that a human rights approach and awareness of power relationships and privilege are visible in the policy documents and teaching content of both universities. Next, I will look at reflective practice and critical thinking, as this was identified in the interviews and medical educator discussion as important ways one could learn about GAHC.

6.4.6 Document analysis: Reflective practice and critical thinking

Reflection is mentioned in the HPCSA Core competencies in broad strokes:

> 6.1.1 (a) Reflect on and acknowledge the strengths and limitations of their knowledge and skills.
> 6.1.1 (e) Reflect on, and learn from, challenges that are experienced in practice by posing appropriate questions, accessing, and interpreting relevant evidence, integrating new learning with practice, evaluating the impact of change in practice, and documenting the learning process (Health Professions Council of South Africa, 2011).

Critical thinking and reflection are mentioned as a learning outcome in documents from both universities. Here are some examples:

> Students learn … critical analysis of and reflection on professional conduct, diversity, health and human rights (University A document 3).

> One of the key questions this course is concerned with is: 'How have the interactions between power, privilege, and identities (linked to, amongst others, 'race', gender, class, abilities, sexuality, and sexual orientation) shaped health care provision and practice in South Africa?' (University A document 5).

Module outcomes include:

- Use reflective learning practices in order to engage in transformative learning.
- Critically reflect on psychosocial and environmental influences on health and healing for individuals and communities (University B document 2).

6.4.7 Discussion of document analysis

There was very limited content on GAHC. The broader aspects of professionalism, patient-centred care, respect for diversity, a human rights approach as well as reflection and critical thinking are documented. Hana et al. (2021) recognises cultural humility as a key element for education on GAHC (Hana et al., 2021). Although not specifically named, it is implied in documents from both universities, as awareness of power relationships and privilege.

Pentecost et al. (2018) write about "a persistent gap between i) the intentions of programme planners (the espoused curriculum); ii) the learning and assessment opportunities that educators create for students (the enacted curriculum) and iii) the manner in which students engage in educational activities (the experienced curriculum)" (Pentecost et al., 2018, p. 226). From this document analysis, the intended/espoused curriculum does speak to the values that underlie GAHC, although there is very little focused content on GAHC. Regarding the learning and assessment opportunities (enacted curriculum), small group discussions and reflective writing exercises were used for broad topics identified in this analysis, although I was not able to ascertain exactly what was assessed. In the experienced curriculum, the values that underlie GAHC was not always evident, as described by the participants in this study in the research stories and themes.

6.5 Schematic presentation of themes

The themes in this chapter are superimposed on the schematic presentation by Cruess & Cruess (2015) below. This is looking at factors affecting the identity formation of a gender-affirming practitioner. The ideal from the document review is on the right in the blue block. Hierarchy and power are on the left, relating to the learning environment. Curriculum themes are grouped around the formal teaching on

the right. The voices of the affected needs to impact on curriculum development, and role models and reflection impact on the socialisation process.

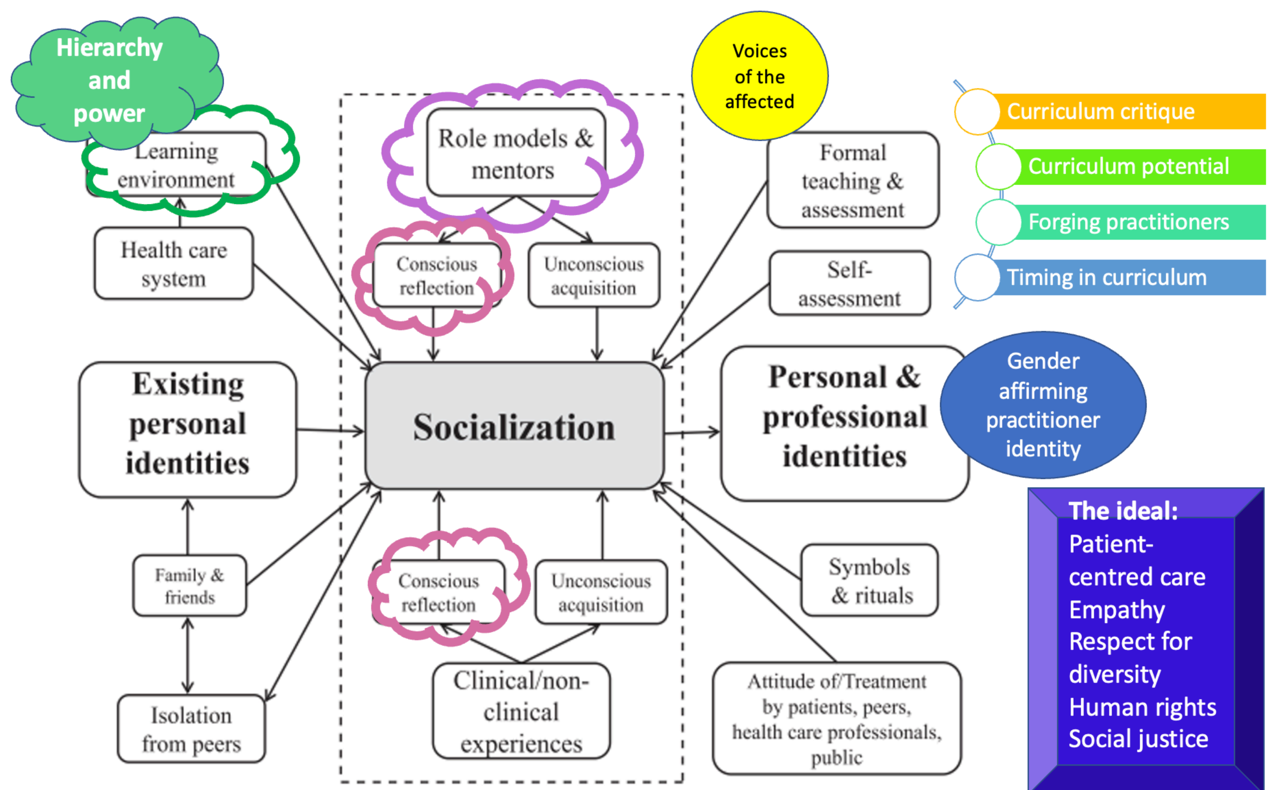


Figure 15: Themes for objective 2 plotted on the graphic by Cruess et al. (2015). Source: author plotted themes on the graphic published by Cruess et al. (2015)

6.6 Summary

This chapter on the role of curriculum in the PIF of a gender-affirming practitioner considered the curriculum from different angles and explored many factors that impact PIF. The environment in which learning happens stands out as key and is described as not conducive to PIF. Creating a conducive environment will require attention to hierarchies as well as the hegemony of heteronormativity and cisnormativity. This is broader than just GAHC. From a decolonial perspective all concepts of superiority and inferiority such as racism, sexism, ableism, heteronormativity and cisnormativity need to be addressed at an institutional level, to create a learning environment that is inclusive, socially just, and constructive. This will benefit not only TGD people, but everyone including students, patients and staff.

Another aspect of the environment is a tension between humanities aspects (such as communication skills) and biomedical sciences. Students do not always value the humanities due to the curriculum being very full.

Power in the curriculum was explored. Student perspectives were that significant change is unlikely if those who have the power to decide what goes into the curriculum have not been exposed to diversity.

Students were critical about the curriculum regarding GAHC, expressing that it is very cis-heteronormative and does not sufficiently prepare them to interact with a TGD person. Student critique of the curriculum is an important aspect of curriculum change, with contestation a necessary phase. Students also discussed the potential of the curriculum, that it gave students access to language about gender diversity, and that learning about human rights influenced how they saw the world.

While there have been South African studies describing the experiences of medical students regarding discrimination (Crombie et al., 2023) and inability to speak about injustices due to feeling silenced by the medical hierarchy (Green-Thompson et al., 2018), this is the first study specifically reporting medical student perspectives on the pervasive cis-heteronormativity in medical schools in South Africa. The curriculum critique specifically regarding GAHC, as well as student perspectives on the necessity of including GAHC in the formal medical curriculum, is a new contribution.

While there are international publications on inclusion of GAHC in medical curricula, this is the first study that gives a voice to South African gender-affirming practitioners and students about what the essential aspects are to include in a medical curriculum, as well as suggestions on strategies to make it happen.

The attitude of health professionals was identified as the most important aspect of GAHC. A practitioner can read up on the detail or can refer if unsure. The basic gender-affirming approach of respect for diversity, empathy and awareness of

pronouns is key, and participants expressed that this needs to be part of communication skills taught early in the curriculum.

The voices of TGD people need to be included when developing training in GAHC. Listening to patient voices was described as a powerful tool in preventing the erosion of empathy. This can be through stories, videos, or direct interaction with students.

Reflection is an important aspect of PIF and is mentioned in the HPCSA Core competencies. Several participants emphasised that reflection about gender identity and prejudice is an important aspect of the process of becoming gender-affirming.

It has been identified by participants that role models have an important role in PIF. Participants lamented that there are not currently sufficient role models of affirming care., Faculty development in GAHC will be important to address this. Integration of GAHC throughout the curriculum will be ideal, as a golden thread linked to patient centred care. It will be a long journey from including GAHC in the intended/espoused curriculum, to having medical educators who can ensure its presence in the enacted curriculum, and for the students to then experience a curriculum where GAHC is valued.

In the next chapter, the different strands will be braided together to describe the case. The case for this study is the process of PIF of a gender-affirming practitioner in a South African context.

Chapter 7 The case – braiding together.

7.1 Introduction

The case for this study is the process of PIF of a gender-affirming practitioner in a South African context. The case is bounded in terms of participants, location, process explored and timeframe. The participants are health professionals and medical students, the location South Africa, the process explored is the PIF of a gender-affirming practitioner and the timeframe is the period during which the data generation took place, 2019-2020. It is a single case with embedded units (practitioners and medical students).

In case study, data from multiple sources are converged in the analysis process, with each data source contributing to understanding the whole phenomenon. "This convergence adds strength to the findings as the various strands of data are braided together to promote a greater understanding of the case" (Baxter & Jack, 2008, p. 554).

From a methodological perspective, I had to hold the tension between using critical theory and narrative inquiry with an inductive approach, and a deductive approach using PIF as a conceptual framework. This was an iterative process between inductive and deductive approaches, to provide more depth to the analysis of the case.

7.2 The context of the case

This case is studied in the context of South African Healthcare in 2019-2020. The legal and policy context has been described in the Literature Review in 2.3 as an enabling environment for the development of GAHC, at least on paper. The context of healthcare in South Africa in which participants provide and experience care, is one where there is much ignorance about GAHC, with stigma, discrimination and experiences of care that are not affirming. This is described in the research stories as well as theme 5.3.3 (Learning from lived experience).

The learning context at medical school is described in research stories 4 and 5 as well as theme 6.3.1 (Medical school environment, hierarchy, and power). It is not conducive to becoming gender-affirming. Different hierarchies are described, between lecturers and students, as well as racism, sexism, heteronormativity and cisnormativity. Students report that these hierarchies make it difficult for them to speak out about discrimination that they experience and observe. Another aspect of the context is the perceived tension between biomedical science and the humanities, that is, “hard skills” and “softer skills”. The latter would include being affirming, which is not valued by both clinicians and students. The document review revealed an intended curriculum with important curriculum components of patient-centred care, empathy, respect for diversity, human rights and social justice. However, the experienced curriculum described by students does not reflect these components.

7.3 The process of PIF

In Chapter 5, I explored the process of PIF of a gender-affirming practitioner, by analysing the narrative interviews of both practitioners and students. How we see was prominent in the research stories. A gender-affirming practitioner is someone who can see the human first, see the identity of the person and not the pathology. It is someone who recognises the patient as someone with agency who can make decisions. There is a shift in the power dynamic, where a gender-affirming practitioner sees themselves as on an equal footing with the patient. A meeting of experts, with the patient an expert on their own lived experience. This is a disruptive idea for traditional ways of viewing a medical encounter; a decolonising perspective to move away from the hierarchy in a consultation.

For this process of becoming a gender-affirming practitioner, there are two intertwined components, namely the attitudinal and knowledge aspects. Different practitioners have different journeys, with some bringing an affirming attitude with them at the start of their journey, and mostly having to learn the knowledge aspect. This can be a messy journey with tensions along the way.

A key component of the journey is to be able to look in the mirror and see oneself. For the trans participants, this was a difficult part of the journey. T describes a time

of not yet being able to look in the mirror, and K that there was a reflection he could not yet embrace. They had to confront internalised transphobia. For cisgender practitioners, it is also crucial to look in the mirror and confront own prejudice so that one is able to be affirming. This includes how one thinks about gender diversity, and, from a critical perspective, about disrupting the gender binary.

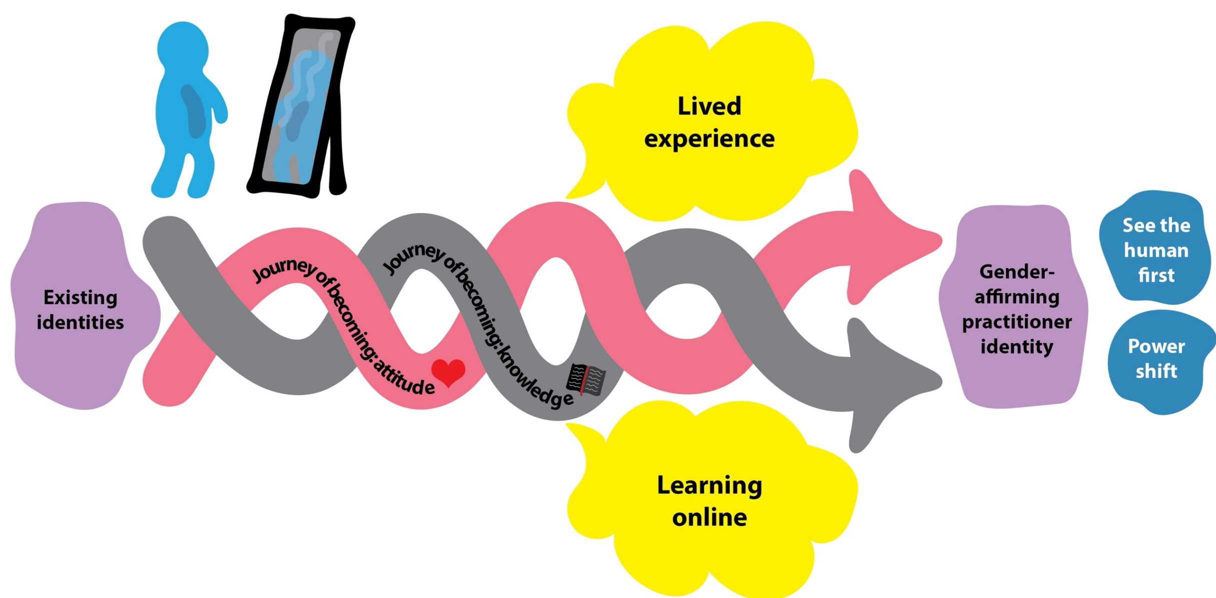


Figure 16: The process of becoming a gender-affirming practitioner
Source: Graphic design by Suki Lock of Jagged Daisy**.**

If one compares the practitioners and students, none of the practitioners learnt about GAHC at medical school. For the students, there was an aspect of learning through the curriculum although criticised as inadequate. For both practitioners and students, there was significant learning through lived experience, whether of self, friends, or patients. The learning about what GAHC is not, from negative experiences of accessing care, was also shared between the two groups. For the students, this

included observing negative role models. The indignation can be a trigger for transformative learning.

Apart from E, the practitioners did not describe learning through a community of practice. For most of them it was initially quite a lonely journey of becoming gender-affirming practitioners. This challenges the notion that PIF can only happen within a community of practice. D managed to create a community of practice where she works. Since the time of the data generation in 2019-2020, PATHSA was established towards the end of 2020, and has become a community of practice to continue learning together about GAHC. For the students, the student societies were an important space to learn, which can be seen as a community of practice.

7.4 How could medical curriculum change enable gender-affirming professional identity formation?

Although being a gender-affirming practitioner is not a "destination" but something to strive towards, this case clearly articulates what gender-affirming is. An affirming approach of seeing the human first is broader than only gender-affirming and applicable to all situations where health professionals interact with patients who are different from them. If this is our goal to have medical graduates that have this as part of their professional identity, how do we get there?

There are two large areas to think about, namely the learning environment, and then the curriculum. I would like to come back to the definition of curriculum by Gerwel, discussed in Chapter 2 (Literature review): Curriculum is the "interlinked complex of who is taught, what is taught, how it is taught, who teaches, and within what context we teach" (Gerwel, 1991, p. 10).

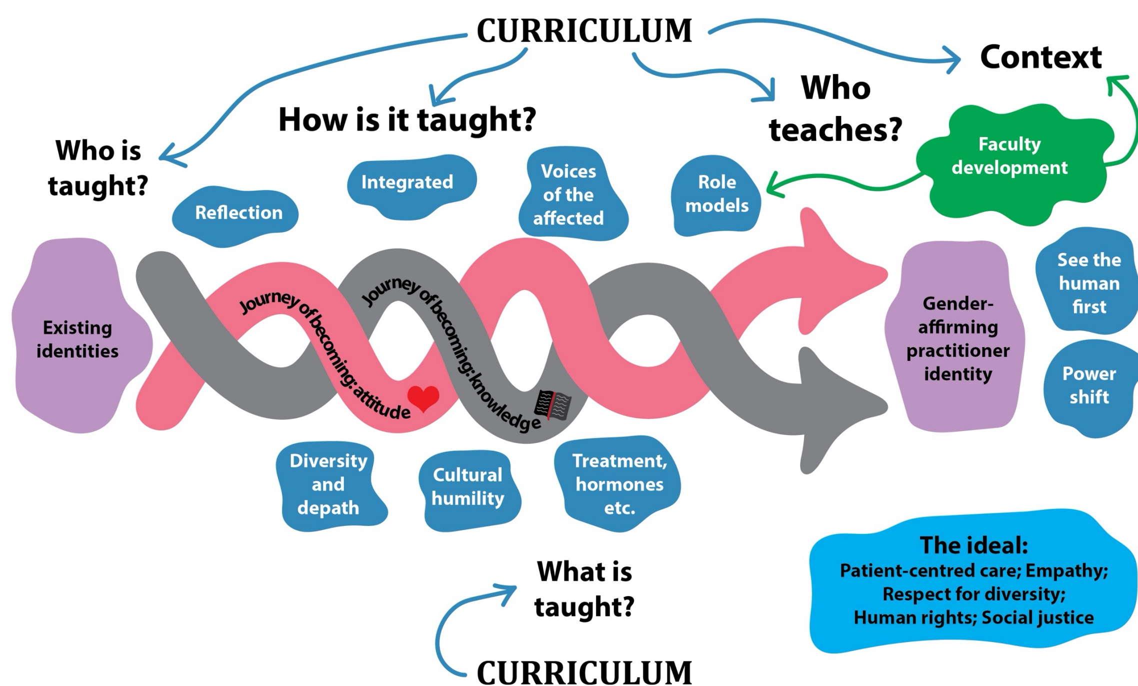


Figure 17: Curriculum potential to facilitate PIF of a gender-affirming practitioner.

Source: Graphic design by Suki Lock of Jagged Daisy**.**

In figure 17, I include the five questions that Gerwel includes in his definition of curriculum (Gerwel, 1991). Who is taught looks at the existing identities that medical students have. As Mokhachane et al. (2023) described, for some students, the identities that they arrive with, will already include aspects of a caring and patient-centred attitude (Mokhachane, et al., 2023) while other students will need significant exposure to new ideas in order to develop an affirming attitude. When considering how to "forge gender affirming practitioners", awareness by educators that students are on a spectrum in terms of their understanding and attitudes about GAHC will be important.

What is taught (at the bottom) is relevant to the knowledge aspect, although specific knowledge can also lead to shifts in attitude. Students need to understand that there are different ways of being that include diversity in sexual orientation and gender

identity, and that assumptions of everyone being heterosexual and cisgender are not accurate. Understanding that being transgender is an identity and not a pathology (a depathologisation perspective) is another important aspect (Castro-Peraza et al., 2019).

A cultural humility approach has been described as a key component of GAHC and will need to form part of what is taught (Hana et al., 2021; McPhail et al., 2016). Although not specifically named as such, this approach has been implied in both the document analysis (section 6.4) and narrative interviews, described in the theme 6.3.4 (Forging gender-affirming practitioners “changing the lens, of how we view our patients”). For me, a cultural humility approach means coming into a consultation with an open mind and deliberately avoid making assumptions, coming with curiosity about what the patient may bring. This approach includes an awareness of power in the consultation, to not come arrogantly as the all-knowing doctor, but with humility as we can often learn so much from our patients. Such an approach will also avoid a situation of epistemic injustice (Thomas et al., 2020), as a cultural humility approach will take the patient’s narrative seriously.

The detail of what would be an appropriate undergraduate curriculum in GAHC that is relevant to the South African context still needs to be determined. The following may be useful for considering which aspects to include: SAHCS GAHC Guideline (Tomson et al., 2021), PsySSA Guidelines for working with sexually and gender diverse people (Psychological Society of South Africa, 2017), the WHO recommendations (Hana et al., 2021) and Canadian undergraduate medical curriculum framework (Ellaway et al., 2022).

Regarding how GAHC is taught, it is critical to bring in reflection. Reflection is a significant aspect of PIF and emerged as an important mechanism for learning about GAHC, as explored in theme 6.3.6 (Reflection “how to give a damn about people with experiences different to your own, that only comes out when you do some introspection and reflection”.) This is related to critical consciousness, which can enable students to reflect on inequities and their own professional power (Bleakley, 2017; Manca et al., 2020). It is important to reflect specifically on one’s own positioning and possible prejudice to become a gender-affirming practitioner

(McGeorge et al., 2021). Transformative learning theory (Van Schalkwyk et al., 2019) can inform thinking about how to create spaces for reflection on “disorientating dilemmas” such as being exposed to negative role models.

Teaching about GAHC needs to be integrated throughout the curriculum and not as a silo. This was explored in theme 6.3.8 (Timing in curriculum and integration “formally incorporated in the preclinical or the junior years, and then followed through a spiral into the senior years”.) It should form part of communication skills that are taught in the early years and revisited in the clinical years as part of patient-centred care.

The voices of TGD people need to be included when developing training in GAHC, as explored in theme 6.3.5 (“The voices of the affected need to be heard”). Listening to patient voices can be a powerful tool in preventing the erosion of empathy. This can be through stories, videos, or direct interaction with students. This can be seen as a decolonial act, to give a voice to the perspectives of those who are marginalised (Behari-Leak & Mokou, 2019).

The question of who teaches, or from whom do students learn about GAHC, was explored in theme 6.3.7 (Role models “it isn’t just enough to have a curriculum that actually deals with this when we as educators, are not role modelling this”). It is a challenge that there are not currently sufficient role models of affirming care, and that there are negative role models who may impact on the PIF of students. In order to address this, faculty development specifically in GAHC will be important, as well as valuing a patient-centred approach (Coleman et al., 2022; Hana et al., 2021).

Gerwel's (1991) question regarding within what context we teach is complex. It is evident that the current learning environment is not conducive to the PIF of a gender-affirming practitioner, as discussed in 7.2. It includes hierarchies, where biomedical science is often valued more than humanistic aspects of medicine, such as being affirming. This needs to be addressed as part of decolonising and changing curricula. Faculty development can play a role in creating shifts in the learning context. The context and role models form part of the HC. The focus of curriculum change should include this and not only focus on the formal curriculum.

7.5 Aspects of power in this case

From a critical pedagogy perspective, I will look at aspects of power in this case, at an institutional level, educator-student relationships as well as in the clinical encounter.

At an institutional level, the faculty leadership would have some power to influence both the learning environment and the curriculum. Paton et al. (2020) have cautioned that this will require new approaches, as using conventional approaches ('the master's tools') may not yield the desired changes. An approach to health professions education that is centred on equity and social justice is needed (Jacobs et al., 2020; Paton et al., 2020) to facilitate the development of critical consciousness in medical students (Manca et al., 2020). As Leibowitz (2017) argues, decolonisation of curricula will not be effective if done in a piecemeal fashion, it will require involvement from all role players (Leibowitz, 2017).

There is a tension here. I argue for the development of critical consciousness in students as part of PIF, that may result in students being more willing to challenge the faculty leadership. Hafferty et al. (2016) described a submission-subversion dialectic, where while on the one hand the aim is to produce graduates that have internalised core occupational values, on the other hand a willingness to resist entrenched assumptions about the profession is required (Hafferty et al., 2016). They describe the paradox that PIF could result in professionals who "seek to disrupt the very systems that gave rise to that identity to begin with" (Hafferty et al., 2016, p.

173). In a changing healthcare system, professionals who will think for themselves and be able to challenge systemic injustice are required, even though it may not be comfortable for faculty leadership.

I assert that an affirmative approach to a patient needs to be mirrored in the way medical educators relate to students. When students can be seen as active participants in their learning, as having a voice, rather than just passive recipients of knowledge, it can contribute to learning (Freire, 1970). In an article on epistemic justice in HPE, Thomas et al (2020) argue that HPE will need to change in 3 aspects: what we teach, how we teach (role modelling epistemic justice where the student has a voice) and with whom we teach (including patients as partners) (Thomas et al., 2020).

Power relationships in clinical encounters have been described in this study as very unequal. In research stories 1 and 2, the practitioners relate their own experiences of accessing healthcare as not affirming at all. A transgender student, DL, described the power dynamic in a consultation, where trans patients feel they must present in a certain way "to be palatable to the doctor", and at times conceal their identity for fear of abuse. This is an example of epistemic injustice, where the patient's narrative is not taken seriously (Fricker, 2007; Thomas et al., 2020). In an affirming approach as described in this study, there is a different power dynamic, where the patient's perspective is acknowledged and respected. Whitehead (2023) challenges power imbalances between medical doctors and persons with disability and recommends the repositioning of and equalising of power in the doctor-patient relationship (Whitehead, 2023). This is relevant for all doctor-patient encounters, whether with a TGD patient, a person with disability or any other person seeking healthcare.

7.6 Summary

This case (the process of PIF of a gender-affirming practitioner in a South African context) sheds light on power relations at three levels: medical school as institution, educator-student interactions as well as in the clinical encounter. A decolonised and affirming approach offers a new perspective, of how these power dynamics may shift to create a more enabling environment for the development of a gender-affirming

professional identity. The next and final chapter will present the conclusion to this study.

Imagine affirmation (on the tune of the song “Imagine” by John Lennon)

Imagine affirmation
It's easy if you try
Imagine there’s no judgement
and no need to cry
Imagine all the people
seen for who they are
Ah

Imagine there's no stigma
It isn't hard to do
Welcoming clinic spaces
Friendly hospitals, too
Imagine all the people
affirmed as who they are

You
You may say I'm a dreamer
But I'm not the only one
a wave of caring people
Will turn healthcare upside down

Imagine there’s no violence
I wonder if you can
diversity respected
and people really seen
Imagine all the people
Sharing all the world

You
You may say I'm a dreamer
But I'm not the only one
I hope someday you'll join us
And the world will live as one

Words adapted by Elma de Vries
Original songwriter: John Winston Lennon
Imagine lyrics © BMG Rights Management, Capitol CMG Publishing, Royalty Network, Songtrust Ave, Sony/ATV Music Publishing LLC, Universal Music Publishing Group

Link to recording:
https://drive.google.com/file/d/1np5fxjfzAzNNlNW8XeTpEJ0Lfto5UzaL/view?usp=sharing

In this final chapter I will provide the conclusion for this thesis as relevant to the objectives for the study. I will reflect on the strengths and limitations as well as make suggestions of what the implications may be.

8.1 Conclusion

I started out in Chapter 1 describing the health inequities in TGD people, and how ignorance from health professionals contribute to this. The aim outlined in the 2030 SDG of leaving no one behind (UN, 2015) seems elusive, with Goal 3 (good health and wellbeing) far from being reached for TGD people globally. This may appear to be a hopeless situation, which is why I find inspiration in how Paulo Freire writes about hope, that it is essential if we want to contribute to changing the world (Freire, 1998). I believe that change is possible, even though the power imbalances I described in Chapter 7 may seem difficult to change. This is why I wrote new lyrics for the song “Imagine” by John Lennon.

Returning to the two objectives for this study:
a. To analyse the process of PIF of gender-affirming health care practitioners and students using narrative interviews.
b. To illuminate how medical curriculum change could enable gender-affirming professional identity formation.

In relation to the first objective, this study found that the process of PIF of a gender-affirming practitioner is very individual. People start the journey at different places, with some already having an affirming attitude, while others have much work to do to confront prejudice. Introspection, “looking in the mirror”, is an important part of this process, to confront pathologising perspectives and to come to a place where TGD people can be seen for who they are.

For the practitioners, this process was enabled through lived experience (own, friends or patients). Central to the findings is the conceptualisation of what gender-affirming means, that it is an affirming approach to every consultation, a lifestyle. The research stories illuminated the patient experience of an affirming consultation, the immense relief when they realise that they will not be judged and will be able to access care. For a consultation to be affirming, a shift in the power relationship is required. The health professional has to recognise the patient experience as valid and respect the patient knowledge about their identity.

What this study adds to the existing literature on PIF, is a specific focus on developing a gender-affirming identity that forms part of a practitioner’s professional identities. Aspects of an affirming identity may already be present prior to entering medical school (Mokhachane, et al., 2023), and it develops further through social interaction and reflection (Wald, 2015a). Development of critical consciousness in medical students is essential to facilitate the PIF of an affirming practitioner, as it allows for critical reflection of one’s own prejudice and power relationships (Jacobs et al., 2020; Manca et al., 2020).

For the second objective regarding curriculum change, the learning environment at medical school is an important factor that can hinder or facilitate PIF. Hierarchical relationships between educators and students can lead to epistemic injustice where

a student does not have a voice to speak out against mistreatment of patients (Thomas et al., 2020). The document analysis found that although the intended curriculum does speak to the values that underlie GAHC, this is not always evident in the experienced curriculum, as described by the participants in the research stories. The attitude of health professionals is the most important aspect of GAHC, that needs to be taught early in the curriculum. It is an attitude of respect for diversity that is broader than just for TGD patients and a component of cultural humility. Integration of GAHC into the curriculum over time is essential in order to have long term impact.

In this study, I learnt so much from the stories of TGD practitioners about what affirming practice means. It is a critical way of looking at gender, to disrupt the gender binary and cisnormativity, and respecting how patients view themselves. Participants learnt from lived experience of self, or others. Listening to the “voices of the affected” is a powerful way of learning from lived experiences and for medical students’ learning (Noonan et al., 2018). This study gives value to the voices of those on the margins, in a society where gender diversity is not always accepted. This can be seen as an example of epistemic justice (Carel & Kidd, 2014).

In answer to the research question, ‘how can the process of PIF of a gender-affirming practitioner inform medical curriculum change?’ I offer this: The process requires confronting pathologising perspectives to come to a place where a health professional can see TGD people for who they are, as human first. Curriculum change can facilitate this by integrating GAHC in the medical curriculum with a focus on attitudes, cultural humility and incorporating the voices of TGD people. This can contribute to social justice in medical education.

8.2 Strengths

I consider one of the strengths of this study to be that I explored unchartered territory, to look at the specific process of the PIF of a gender-affirming practitioner. This study has elaborated on how gender-affirming practice is conceptualised by practitioners and experienced by patients.

The affirming approach as described in this thesis has a gift for medical education, an opportunity to rethink power relations at three levels: in medical school, when medical educators and students interact, as well as in the clinical encounter. As a researcher, I have been challenged in my own thinking about power relations at these levels, coming from a traditional medical training to a new understanding of a decolonising approach to medical educator-student and doctor-patient relationships – seeing the student and patient as a human being first. I consider it a strength of this study that I was willing to take this risk to learn, and to keep on learning. This learning did not come easily. I had to reflect on the way I had been trained in medicine, where what did not fit into the norm was pathologised and needed to be fixed (positivist perspective). I realised that it was important to take a depathologising stance in this research, to see gender diversity as part of the diversity of humanity.

A strength of this study is its contribution to theory on PIF, specifically on how curriculum change can contribute to the PIF of a gender-affirming practitioner.

Another strength of this study is the alignment of the critical paradigmatic positioning and the methodological choices of narrative inquiry and reflexive thematic analysis to explore the case. This allowed me to explore issues of power in medical education, through the stories of participants, with a deep awareness of my own positionality.

I consider my positionality as another strength. I identify as non-binary and part of the TGD community and have been an activist for improving access to GAHC for many years. This gave me an insider perspective and led to participants trusting me to share their stories openly. As a medical educator, and coordinator of a new undergraduate medical programme, I could deeply reflect on curriculum and the implications of this research.

8.3 Limitations

This was an interdisciplinary study, which limited the depth to which I could explore different bodies of knowledge. For this study, I utilised the theory of PIF as described in medical education. There is extensive literature on PIF, going into detail of the individualist as well as social-contextual perspectives. In Chapter 3 I covered this in

as much detail as this study would allow, while recognising that other studies may have gone into more detail. Similarly, both gender studies and curriculum studies are vast fields to explore, but going deeper into each would have been taken the focus away from this particular thesis.

In qualitative research, the researcher is a research instrument and not objective (McGrath et al., 2018). It is understood that in qualitative research there is a subjective element to knowledge production, which could be seen as a limitation as well as a strength (Braun & Clarke, 2019). Polkinghorne (2007) has described limitations to narrative inquiry, that there may be a disjunction between a person's actual experienced meaning and their storied description due to:

> (a) the limits of language to capture the complexity and depth of experienced meaning, (b) the limits of reflection to bring notice to the layers of meaning that are present outside of awareness, (c) the resistance of people because of social desirability to reveal fully the entire complexities of the felt meanings of which they are aware, and (d) the complexity caused by the fact that texts are often a co-creation of the interviewer and participant (Polkinghorne, 2007, p. 480).

In this study, all these may be possible. The practitioners were known to me prior to the study, and we continued to have interaction during the data generation and analysis period with the development process of the SAHCS GAHC Guideline. While this might be considered problematic, there are advantages to relational ways of conducting narrative inquiry research, such as that the close relationship between the narrative inquirer and participant can facilitate a deeper understanding of the lived experience under study (Kim, 2016).

Document review was one of the sources of data for the case. It was a limitation that only certain documents related to curriculum were available from university A and B. For example, I was not able to access the HPCSA accreditation reports as they were regarded as confidential documents by the institutions.

A logistical limitation was that the students, documents and medical educators were sampled from only two of the ten medical schools in South Africa. Because of the scope of the study, it would not have been feasible to include all ten medical schools.

The students, documents and medical educators were sampled from only two of the ten medical schools in South Africa. Although a limitation of case study research has been described that it is not always possible to generalise from a case study, Flyvbjerg (2006) argues that "one can often generalize on the basis of a single case, and the case study may be central to scientific development" (Flyvbjerg, 2006, p. 228). While the findings for this study cannot be generalised, it does create a picture of a specific case in a South African context, the case of the PIF of a gender-affirming practitioner.

8.4 Implications

8.4.1 Implications for the medical school environment

The findings create the opportunity for medical schools to rethink power relations and what learning environment is created (Galvaan et al., 2019; Green-Thompson et al., 2018). How can an environment be created where the hegemony of sexism, racism, ableism, cisnormativity and heteronormativity is challenged, as well as the humanistic aspects of medicine, such as an affirming approach, is valued? Faculty development of medical educators is essential to facilitate positive role modelling of affirming care (Hana et al., 2021) as well as an understanding of the importance of fostering critical consciousness in medical students (Jacobs et al., 2020). Faculty development to look through a decolonial lens at the power relations when medical educators and students interact can challenge established hierarchies (Galvaan et al., 2019).

8.4.2 Implications for curriculum change

From the findings in this study and the literature (MacKinnon et al., 2021), it is clear that an integrated approach is needed to include GAHC in a curriculum. An attitude of respect for diversity that is broader than just for TGD patients, of which cultural humility is a component (Hana et al., 2021; Tervalon & Murray-García, 1998), needs to be taught early in the curriculum. This could form part of including medical humanities in a medical curriculum and could facilitate the development of critical consciousness, where students can develop a deep, reflexive awareness of professional power and patient-centred practices (Bleakley, 2017; Kumagai & Lypson, 2009; Manca et al., 2020).

At a national level, I recommend that the HPCSA develop an Ethical booklet as part of the existing series “Ethical guidelines for good practice in the health care professions”, which currently consists of 17 booklets. It should specifically address Ethical practice with sexually and gender diverse patients that will be applicable to all health professions that are registered with the HPCSA, as all health practitioners will come into contact with sexually and gender diverse patients. This could then be used by all Faculties of Health Sciences in future, to help prepare students for affirming practice.

8.4.3 Implications for research

This research paves the way for others looking to explore PIF specifically in the field of GAHC. Another research question that arises is how faculty development could assist medical educators to foster critical consciousness in medical students.

I would like to join other researchers (Nolan et al., 2020) in calling for further studies on how best to include GAHC in medical curricula.

8.5 Final reflection

Kim (2016) asserts that the ultimate goal of narrative inquiry is “to make a difference in society by planting a seed for social justice” (Kim, 2016, p. 237). I offer the findings and implications of this study, to plant a seed for curriculum change that may eventually have the impact that many more TGD people are able to access care that is affirming.

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APPENDIX 1 HUMAN RESEARCH ETHICS APPROVAL 2019

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumayah.ariefdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

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19 August 2019

HREC REF: 399/2019

Prof H Kathard
Health & Rehab Sciences
F-45
OMB

Dear Prof Kathard

PROJECT TITLE: HOW CAN THE PROCESS OF PROFESSIONAL IDENTITY FORMATION OF A GENDER-AFFIRMING PRACTITIONER INFORM MEDICAL CURRICULUM CHANGE? (PHD CANDIDATE: DR E DE VRIES)

Thank you for your response letter dated 29 July 2019, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 August 2020.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student: - Dr Elma de Vries will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

APPENDIX 2 HUMAN RESEARCH ETHICS RENEWAL 2023

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938) **This serves as notification of annual approval, including any documentation described below.**			
☑ Approved	Annual progress report	Approved until/next renewal date	30.11.2024
☐ Not approved	See attached comments		
Signature Chairperson of the HREC/ Designee	[signature]	Date Signed	15/11/2023

Note: Please email this form and supporting documents (if applicable) in a combined pdf file to hrec-enquiries@uct.ac.za.
Please clarify your plan for research-related activities during COVID-19 lockdown.
Please use the latest form found on our website:
http://www.health.uct.ac.za/fhs/research/humanethics/forms

HUMAN RESEARCH ETHICS COMMITTEE
15 NOV 2023
HEALTH SCIENCES FACULTY UNIVERSITY OF CAPE TOWN

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	11 November 2023		
HREC REF Number	399/2019	Current Ethics Approval was granted until	30-11-2023
Protocol title	How can the process of professional identity formation of a gender-affirming practitioner inform medical curriculum change?		
Protocol number (if applicable)	V2		
Are there any sub-studies linked to this study?	☐ Yes	✓ No	
If yes, could you please provide the HREC Reference number for all sub-studies? **Note:** A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	Prof. Harsha Kathard		
Department / Office Internal Mail Address	Harsha.Kathard@uct.ac.za		

28 February 2022 | Page 1 of 7 | FHS016

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

APPENDIX 3 INFORMATION SHEET AND CONSENT FORM: NARRATIVE INTERVIEWS

CONSENT TO TAKE PART IN RESEARCH: NARRATIVE INTERVIEWS

Study title: How can the process of professional identity formation of a gender-affirming practitioner inform medical curriculum change?
Principal Investigator: Dr. Elma de Vries

You are being asked to take part in a research study.Taking part in research is voluntary.

Why is this study being done?
This study is being done to better understand the process of becoming a gender-affirming practitioner in order to make recommendations for curriculum change.

Why are you being asked to take part?
You are being asked to take part as you have been identified as someone who will be able to share information about your journey of becoming a gender-affirming practitioner.

How many people will take part in the study?
The interview phase of the study will include around 8 practitioners and 8 students. The group discussion in phase 2 will include a group of around 20 medical educators.

How long will the study last?
Data generation will be for a period of 12-24 months, during which more than one interview per participant may take place.

What will happen if you decide to take part in the study? What are the risks and discomforts of this study?
If you decide to take part, the researcher will arrange an initial interview with you and request you to journal about your experience in electronic or written form. The researcher will ask permission for audio recording of the interview. You will be asked

a series of questions in this interview. If you wish to not answer a question, you will have the option of not answering. This interview will take approximately 1-2 hours. Following this interview there may be 2-3 further interviews for clarification and further exploration, the duration of each interview approximately 1-2 hours. The audio recordings will be transcribed and analysed, and the journal will be analysed. It will be securely kept for a period of one year after completion of the study and then destroyed.

There is the potential risk of becoming emotionally upset during the interview. If this happens you may stop the interview at any time.

Are there any benefits to you for being in the study?
You might not personally benefit from being in this research study. There is potential benefit as you will be contributing to the research project aimed at making recommendations for including gender-affirming care in future medical education curricula.

What other choices do you have?
You have the option to decline participation in this study.

What will happen when the study is over?
When the study is over, a dissertation will be written.

Will the results of the research be shared with you?
The results will be shared with you in the form of an electronic copy of the dissertation.

Will you receive any reward (money or food vouchers) for taking part in this study?
You will not receive any reward for taking part in this study apart from refreshments during the interview.

Who will see the information which is collected about you during the study?
The principal researcher and her supervisors will see the information. Full names will not be used in the research report, and you may choose a pseudonym or a letter/ letters e.g. initial(s) to be used. The degree of anonymization of your information will be discussed with you and agreed upon in writing. This agreement will be respected for the research report, thesis and any publications arising from the research.

Who do I speak to (or contact) if I have any questions about the study?
The principal researcher Elma de Vries may be contacted at elma.devries@uct.ac.za or 082 8286259 with any concerns.

The UCT's Faculty of Health Sciences Human Research Ethics Committee can be contacted in case you have any ethical concerns or questions about your rights or welfare as a participant on this research study:
Floor E53, Room 46, Old Main Building, Groote Schuur Hospital, Observatory, 7925, or on 021 406 6492; 021 404 7682; 021 406 6626 or hrec-enquiries@uct.ac.za

CONSENT
I have read the above information about the study entitled "How can a medical curriculum facilitate the process of professional identity formation of a gender-affirming practitioner?" and have been given time to ask questions.I agree to take part in this study, and I will be given a copy of this signed consent form.

I prefer to remain completely anonymous Yes / No (please circle)

I prefer to be referred to by the following pseudonym _____________ or letter(s)___

____

Participant's Signature and Date PRINTED NAME

____

Researcher Signature and Date PRINTED NAME

Appendix 4 Interview guide: narrative interviews

For health professionals:

Please tell me about where you practice? For how long have you been in practice?
What does ‘being gender affirming’ mean to you?
How did you become interested in gender-affirming care?
Where did you learn about gender-affirming care?”
What kinds of gender-affirming care do you currently provide?
Can you remember a moment that really shaped your attitude towards gender-affirming care? What happened? What did it do to you?
Could you tell me about your journey of becoming a gender-affirming practitioner?”
What role did the curriculum play in this process and what role could it play?
Have you experienced issues of power in the curriculum? Would you like to discuss this?

For medical students:

How did you become interested in gender-affirming care?
What does gender ‘being gender affirming’ mean to you?
Can you remember a moment that really shaped your attitude towards gender-affirming care? What happened? What did it do to you?
Could you tell me about your journey of becoming as a medical student, regarding being gender affirming?
What role did the curriculum play in this process and what role could it play?
Have you experienced issues of power in the curriculum? Would you like to discuss this?

APPENDIX 5 INFORMATION SHEET AND CONSENT FORM: FACILITATED GROUP DISCUSSION

CONSENT TO TAKE PART IN RESEARCH: FACILITATED GROUP DISCUSSION

Study title: How can the process of professional identity formation of a gender-affirming practitioner inform medical curriculum change?
Principal Investigator: Dr. Elma de Vries

You are being asked to take part in a research study.Taking part in research is voluntary.

Why is this study being done?
This study is being done to better understand the process of becoming a gender-affirming practitioner in order to make recommendations for curriculum change.

Why are you being asked to take part?
You are being asked to take part as you have been identified as a medical educator who may have ideas about ways in which a curriculum could provide an environment in which the professional identity formation of a gender-affirming practitioner can take place.

How many people will take part in the study?
The interview phase of the study will include around 8 practitioners and 8 students. The group discussion in phase 2 will include a group of around 20 medical educators.

How long will the study last?
Data generation will be for a period of 12-24 months.

What will happen if you decide to take part in the study? What are the risks and discomforts of this study?
If you decide to take part, the researcher will invite you to a group discussion of the findings of the first phase of the research. The duration will be approximately 2

hours. This will be audio recorded and transcribed. There is the potential risk of becoming emotionally upset during the group discussion. If this happens you may leave the group discussion at any time.

Are there any benefits to you for being in the study?
You might not personally benefit from being in this research study. There is potential benefit as you will be contributing to the research project aimed at making recommendations for including gender-affirming care future medical education curricula.

What other choices do you have?
You have the option to decline participation in this study.

What will happen when the study is over?
When the study is over, a dissertation will be written.

Will the results of the research be shared with you?
The results will be shared with you in the form of an electronic copy of the dissertation.

Will you receive any reward (money or food vouchers) for taking part in this study?
You will not receive any reward for taking part in this study apart from refreshments during the group discussion.

Who will see the information which is collected about you during the study?
The principal researcher and her supervisors will see the information. The information will be anonymised for the research report, thesis and any publications arising from the research. For the group discussion, the researcher cannot guarantee that participants' confidentiality will be maintained as other participants in the group may disclose what was discussed with persons outside the group. The researcher will request that focus group members respect each other's confidentiality by not speaking to others about matters raised in the group.

Who do I speak to (or contact) if I have any questions about the study?

The principal researcher Elma de Vries may be contacted at elma.devries@uct.ac.za or 082 8286259 with any concerns.

The UCT's Faculty of Health Sciences Human Research Ethics Committee can be contacted in case you have any ethical concerns or questions about your rights or welfare as a participant on this research study:

Floor E53, Room 46, Old Main Building, Groote Schuur Hospital, Observatory, 7925, or on 021 406 6492; 021 404 7682; 021 406 6626 or hrec-enquiries@uct.ac.za

CONSENT

I have read the above information about the study entitled "How can a medical curriculum facilitate the process of professional identity formation of a gender-affirming practitioner?" and have been given time to ask questions.I agree to take part in this study, and I will be given a copy of this signed consent form.

____

Participant's Signature and Date PRINTED NAME

____

Researcher Signature and Date PRINTED NAME

Appendix 6 Discussion GUIDE: GROUP DISCUSSION

The main findings of phase 1 was presented to the group.

Questions for discussion:

What is your response to the findings presented?

What stands out for you?

Based on your experience as a medical educator, are there things you strongly agree or disagree with?

The discussion can explore reasons for agreeing / disagreeing with the findings.

Can you suggest ways in which a curriculum could provide an environment in which the professional identity formation of a gender-affirming practitioner can take place?

What curriculum change would be required to make this possible?

How can barriers to changing the curriculum be overcome?