“MORE THAN JUST WORDS:” A THEMATIC ANALYSIS OF BLACK TRANSGENDER AND GENDER DIVERSE PEOPLE’S MEDICAL EXPERIENCES

By

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Dedication

This project is dedicated to the voices who have not felt heard when seeking medical care. May we continue to listen and amplify these voices.

Table of Contents

Abstract

This thesis project aimed to explore how provider language impacts medical experiences for Black transgender and gender diverse (TGD) people in Nova Scotia. Nova Scotia is home to historic Black communities and a large TGD population (StatCan, 2019; StatCan, 2022), however previous health-related research has not focused on Black TGD populations. To fill the current gaps in the literature, semi-structured interviews were conducted with four Black TGD people in Nova Scotia who were asked to share about their past medical experiences. The interview transcripts were coded and analyzed using thematic analysis guided by social constructionism and Black trans feminism. Five themes emerged including Barriers to Care, Assumptions and Non-affirming Language, Affirming Language, Provider Identity and Communication Style, and Medicine: Medical Terms, Medical Education, and Medical Training. Participants recalled both positive and negative experiences with medical care and suggested methods to improve the language used by medical providers. These findings contribute to understanding the unique experiences of this patient population. Findings may be significant for medical providers in their clinical practice and may be used to adapt medical education to account for the needs of this patient population.

List of Abbreviations Used

APA = American Psychological Association
BTF = Black Trans Feminism
CPATH = Canadian Professional Association for Transgender Health
DSM = Diagnostic and Statistical Manual of Mental Disorders
EDIA = Equity, Diversity, Inclusion, and Accessibility
GID = Gender Identity Disorder
ICD = International Classification of Diseases
LGBTQIA2S+ = Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two Spirit, etc.
TGD = Transgender and Gender Diverse
WHO = World Health Organization
WPATH = World Professional Association for Transgender Health

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Chapter 1: Introduction

> We can come to understand language as more than just words; it's a method of communication, a tool for understanding ourselves, an archive that marks history in time, and a mirror that reflects the society we are in, including the bias that otherwise goes unseen (Choudrey, 2022, p. 40).

Language is powerful in shaping experiences while serving as a reflection of societal norms and ideals. Thus, the language medical providers use can have a significant influence on medical experiences and the overall health of patients. For Black and gender diverse people, medicine and medical discourse have played an essential role in shaping historical and present medical and social experiences. This chapter introduces this study, which analyzed language used by medical providers as recounted by Black transgender and gender diverse (TGD) people in Nova Scotia. This chapter provides relevant contextual information about present day medical experiences of Black TGD people. This chapter also identifies gaps in the current literature and introduces this study's purpose, methodological approach, guiding research questions, and sub-topics.

Black TGD People

Black TGD populations face oppression through medical language that results from the combination of multiple forms of discrimination. Anti-Black racism refers to the "specific form of racism, rooted in the history and experience of enslavement, that is targeted against Black people" (Dryden & Nnorom, 2021, p. 55). Transphobia is the hatred, fear, and prejudicial treatment or discrimination toward TGD people based on their gender identity (Worthen, 2016). Thus, anti-Black transphobia is the unique and dynamic amalgamation of anti-Black racism and transphobia. Unfortunately, experiences of anti-Black transphobia in medical settings have not been documented in Canadian literature.

In the United States, Black TGD people have been found to experience higher rates of medical discrimination than white TGD people (Howard et al., 2019; Kattari et al., 2015; Seelman et al., 2021). Black and other racialized TGD people have shared that both the anticipation of, and the lived experience of, medical discrimination negatively impacts their healthcare utilization, the quality of care they receive, and their mental and physical health (Agénor et al., 2022). Howard et al. (2019) interviewed Black and other racialized TGD people in the United States and revealed that a main facet of negative healthcare experiences shared by participants was providers' use of incorrect names and pronouns and refusing to respect their gender identity (Howard et al., 2019). Factors such as these likely contribute to the fact that, in Canada, Black and other racialized TGD youth have lower overall health compared to white TGD youth (TransPulse, 2019). Although Black and other racialized respondents in the TransPulse (2019) study had similar access to healthcare as white respondents, Black and other racialized respondents were less sure or not planning to seek gender-affirming medical care. Additionally, a significantly higher percentage of Black and other racialized trans and non-binary respondents avoided calling 911 for emergency medical services than white respondents (TransPulse, 2019). This may be due to the higher rates of major lifetime discrimination and anticipated discrimination among racialized participants in this study (TransPulse, 2019).

Communication and language have been identified as meaningful facets of clinical encounters between patients that have been marginalized and their providers in numerous studies (Gahagan & Subirana-Malaret, 2018, Goins & Pye, 2013; Howard et al., 2019). For example, Hudson's (2019) study found that when Black and other racialized TGD people had a racialized or TGD provider, it led to increased trust, confidence in the provider's knowledge, and more positive patient-provider communication. Howard et al.'s (2019) study also concluded that racial concordance between patient and provider improved communication and patient satisfaction for TGD patients of colour. Communication and language are often mentioned yet seldom explored in depth for their impact on quality of care for Black TGD patients.

Trans and Gender Diverse People

Information about how medical discourse has impacted TGD people throughout history is relevant to provide context to Black TGD medical experiences today. Medicine and medical discourse have shaped and controlled TGD people's experiences and access to affirming medical care by creating restrictive and pathologizing labels and criteria for care (Stryker, 2017). Individuals whose gender identity does not match their sex assigned at birth have existed for centuries (Stryker, 2017; Snorton, 2017). A multitude of terms or labels, like *transsexual*, *transvestite*, or *transgendered*, have been used throughout history to refer to this population, many of which have been pathologizing and discriminatory (Stryker, 2017; Snorton, 2017).

Discourses have also gatekept access to gender-affirming medical interventions, which are a critical component of transition processes for many TGD people and have been associated with feelings of gender euphoria and relief as well as improved health and wellbeing (Austin et al., 2022). Hormone therapy has been shown to improve comfort and satisfaction with one's identity, body, and appearance, as well as resilience (Sevelius et al., 2021). Although medicine can be used to affirm one's gender, it is critical to note that the medical field also holds the power to restrict, gatekeep, and judge TGD communities (Stryker, 2017). To make sense of gender-affirming medical care under conventional biomedical models of disease and treatment, doctors and researchers first had to rationalize a pathology in TGD people, allowing only those who fit a set of particular "symptoms" to obtain gender-affirming care (Stryker, 2017, p. 53). Thus, medicine can be a powerful tool for the social regulation of TGD lives.

Black People

Medical discourse has shaped Black people's experiences throughout history, and understanding those discourses provides critical information about Black TGD medical experiences today. In past centuries, medical discourses have cast Black people as inferior, reinforcing false ideals about the biological basis of race which still impact the way medicine is practiced today (Dryden & Nnorom, 2021; Dryden, 2022). In recent decades, research on medical systems and practices has revealed current manifestations of these historically oppressive discourses. Johnson et al. (2004), who explored the association between a patient's race and patient-physician communication during medical appointments, revealed that physicians were more verbally dominant and demonstrated less patient-centred communication with Black patients than with white patients. Beach et al. (2010) analyzed recordings between American physicians and their patients across racial categories. They corroborated Johnson et al.'s (2004) results, as they found physicians were more verbally dominant with Black patients. While examining electronic medical records, Sun et al. (2022) revealed racial bias in patient descriptors where Black patients were 2.54 times more likely to have one or more negative descriptor(s) in their electronic medical record notes than patients of other races. This indicates bias in language, labels, and descriptors used by medical providers. As these examples demonstrate, throughout history, and still today, medical discourse has been a factor that reflects and perpetuates the marginalization of Black people.

This Study

This study was interested in the medical experiences of Black TGD people. Through a thematic analysis of interviews with Black TGD individuals in Nova Scotia, I explored the participants experiences of language they recalled from patient-provider interactions. For the purposes of this study, participants were able to share any medical experience, clinical encounter, or interaction with the healthcare system. This study addresses gaps in the literature on Black TGD people's experiences with medical care. Findings contribute to growing literature about individuals who exist at the intersection of more than one identity that has been marginalized and provide information about their experiences in medicine in a Canadian setting.

Theoretical Framework and Research Paradigm

This study employed Black trans feminism (BTF) to grasp a holistic understanding of patients' experiences and the reproduction of meaning surrounding various identities through providers' language. BTF bridges Black feminism and trans studies to deconstruct the regulative norms surrounding race, sex, and gender (Bey, 2022). It is a transformative theory used to displace, transform, and problematize hegemonic understandings of identity and to theorize how power is related to such identities (Bey, 2022). This study was also guided by a social constructionist paradigm which views identities and experiences as socially constructed through relevant historical and cultural contexts (Burr, 1995). This aligns with BTF theories because social constructionism is also used to critique dominant assumptions in society and acknowledges the way cultural knowledge and identities are socially produced (Bey, 2022; Burr, 1995).

Gaps in the Literature

There is a dearth of research focused on the needs of TGD communities (Casey, 2019). This lack of information creates further challenges when attempting to conduct intersectional analyses that consider the impact of race or ethnicity on TGD people's experiences. Further, there are barriers to identifying TGD communities because Statistics Canada did not begin asking questions about gender and sex assigned at birth until the 2021 census (Casey, 2019; StatCan, 2020).

In 2019, Jack Woodman, the then-president of the Canadian Professional Association for Transgender Health (CPATH), recognized intersectional research on TGD health in a list of directives to reduce healthcare barriers for TGD people. Woodman (2019) emphasized that transphobia is compounded by racism, homophobia, ageism, and other forms of discrimination, which increases risk for those of more than one identity that has been marginalized and creates a need for culturally tailored approaches for research, service planning, and service delivery. Monica Ghabrial (2017) also noted the potential of intersectional research to inform medical professionals and contribute to more positive clinical encounters. Additionally, Ghabrial (2017) explained the importance of focusing medical research on Black and other racialized TGD people, who represent one of the most marginalized communities in society while being relatively excluded from research. This project addresses this gap by focusing on the medical experiences of Black TGD people in Nova Scotia, and the findings are significant for future research and service provision.

Statement of Purpose, Research Question and Subtopics

The purpose of this qualitative study was to investigate the medical experiences of Black TGD people in Nova Scotia and, in doing so, reveal ways in which medical discourse acts as a barrier and/or facilitator of positive clinical interactions and patient satisfaction with services.

Thus, the study's main research question was: How does language impact medical experiences and quality of care for Black TGD people?

The sub-topics were: Affirming language, non-affirming language, identity negotiations, and medical terms and education.

Interviewing Black TGD people in Nova Scotia and discussing their medical experiences with specific attention to provider language allowed me to explore these questions. Additionally, the focus on language allowed participants to share their experiences in medical settings and offer recommendations for improving medical language and communication. Using thematic analysis, I worked to reveal patterns in discourses of oppression and language that (continue to) pathologize Black TGD populations. The findings indicate how language impacts clinical encounters and have been used to develop recommendations for medical providers to empower and connect with Black TGD patients.

Researcher's Interest in the Topic

I grew up in Toronto and was raised by two parents who work in healthcare which initiated my interested in medicine from an early age. My mother completed a thesis as part of her degree in Occupational Therapy in the 1980s and focused on the postoperative care of trans patients. My father is a family doctor who works with young adults. On "Take you kid to work" day in Grade 9 my dad took me to his clinic, and I met a racialized trans man who shared with me how impactful it was to have a doctor who listened and respected him. This opened my eyes to some of the healthcare disparities faced by trans people, particularly trans people of colour.

Throughout my undergraduate degree in health, we often got to pick what specific area of health we wanted to study, and I was always interested in focusing on the health of TGD people and Black people. Before deciding on my topic for this thesis I read existing literature in Canada, and specifically in Nova Scotia, and noticed there was a gap in the literature and that Black TGD people's experiences were not being shared. As much as there are limitations related to my identity, as a cisgender woman, conducting this research, I hope to use my privilege as a biracial cisgender graduate and medical student to focus my efforts on Black TGD health. I will be attending Dalhousie medical school after this degree and my intention with this thesis project was to learn more about Black TGD communities so I can be an informed ally for these populations. I hope to share what I have learned through this project with peers and educators to bring awareness and highlight Black TGD experiences.

Summary

Black and TGD populations have been, and continue to be, pathologized by medical discourse (Johnson, 2018; Snorton, 2017; Styker, 2017). Previous studies have provided important contextual information for this study, however, have failed to account for the nuances of Black TGD experiences in Canada. This study explores how language impacts medical experiences for Black TGD patients in Nova Scotia. Interviews were analyzed using a thematic analysis approach guided by Black trans feminism and social constructionism.

Chapter 2: Literature Review

This chapter provides an overview of relevant terminology and current literature examining the historic and present medical experiences of Black TGD people. The chapter begins by defining different TGD identities and Black identity. Next, the lived realities of Black TGD people's medical experiences as documented in previous literature are outlined. Unfortunately, there is limited scholarly literature on the experiences of Black TGD people because historically, research has siloed racialized and TGD experiences. Although the experiences of Black TGD individuals are not equivalent to the sum of white TGD experiences and Black experiences, I draw from studies about TGD people and Black people in Canada when this intersectional information is not available.

Transgender and Gender Diverse Identities

It is important to understand the difference between *sex* and *gender* when discussing diverse gender identities. Sex is understood as a biological classification of identity based on genitalia, reproductive organs, and chromosomes, among other factors (Vincent, 2018). Gender is related to gender identity and gender expression because gender is both an internal and an external process (Stryker, 2017). Gender identity refers to an individual's internal sense of their gender, which may not fit within the man/woman binary (Stryker, 2017). A person's gender identity is distinct from their gender expression, although they may align. Gender expression refers to the outward presentation of gender, which can be shown through one's name or pronouns, the clothing or hairstyle they have, their behaviour, and other external characteristics (Stryker, 2017). While these distinct conceptualizations of sex and gender are helpful, it is important not to imply a strict delineation between sex and gender. Framing sex as purely biological and gender as purely psychosocial disregards how sex can also be subject to social interpretation (Vincent, 2019). Sex and gender, thus, are best represented as a multifactorial, interlinked system as opposed to isolated entities (Vincent, 2019).

While discussing sex and gender, it is important to consider intersex people and their unique challenges when navigating medical systems (Davis et al., 2016). Intersex people are born with biological sex characteristics that do not fit within the typical binary notions of male or female bodies (Davis et al., 2016). Intersex people typically have both male and female sex traits, which may include genital, gonadal, and/or chromosomal sex traits (Davis et al., 2016). Both intersex and TGD people disrupt binary understandings about sex and gender and may experience similar discrimination and challenges, however, these identities should not be conflated and may have significantly different experiences especially with medical providers (Davis et al., 2016). One key difference noted by Davis et al (2016) is the haste with which medical providers will operate on young intersex people which starkly contrasts the reluctance to surgically affirm TGD people's gender. I recognize the diversity in medical experiences depending on many factors including one's specific sexual and/or gender identity while remaining grounded in the similar oppressive forces experienced by all individuals who do not fit within the binaries of biological sex or are not cisgender.

Current literature defines *transgender*, or trans as a short form, as an umbrella term for any individual whose gender identity differs from the sex they were assigned at birth (Stryker, 2017; Veale et al., 2015; Vincent, 2019). Stryker (2017) explained trans identity as crossing over "the boundaries constructed by their culture to define and contain that gender" (p. 1). For trans individuals, both their gender identity and biological sex may differ from their gender expression. This study recognizes the dynamic nature of the term transgender as meanings continue to adapt to meet the needs of this population. The term *non-binary* refers to people whose gender is not exclusively man or woman, referring to people whose gender exists somewhere between or outside the continuum of gender (Vincent, 2019). This study used the term *transgender and gender diverse* (TGD) as an umbrella term to refer to people who identify as transgender, non-binary, or other diverse gender identities.

TGD people have faced numerous challenges navigating societal structures and systems, including the medical system. These challenges stem from systemic transphobia and cisnormativity. Transphobia is the hatred, fear, and prejudicial treatment or discrimination toward TGD people based on their gender identity (Worthen, 2016). Cisnormativity is the assumption that it is “normal” to be cisgender and situates the cisgender identity as the default identity in society (Schilt & Westbrook, 2009; Worthen, 2016). This study seeks to acknowledge the lasting impacts of these challenges and reveal how discourses used today may reflect these ideals or work to contest these rigid norms.

Black Identity

I use the term *Black* to refer to people of African descent, meaning anyone with African ancestry (United Nations, n.d.). Historically, race-related research has focused on biological differences between races, however, this has proven insignificant (Cormack et al., 2019; Dryden & Nnorom, 2021; Egede, 2004; Este et al., 2018). Although biologically insignificant, race has proven to be immensely socially meaningful, as one’s race has a large impact on their social reality (Egede, 2004; Este et al., 2018). It is important to examine the experiences of Black communities within Nova Scotia because of the large and centuries-old communities of African Nova Scotians (Dryden & Nnorom, 2021; StatCan, 2019). Central to conversations about Black identity are explorations of systemic anti-Black racism that shape the socio-medical experiences of Black people in Canada (Dryden & Nnorom, 2021; Owino et al., 2022). Personal and systemic anti-Black racism exist as forms of structural violence that shape how the medical system has historically and presently marginalized and excluded Black people in Canada (Owino et al., 2022).

Black TGD People's Medical Experiences

Understanding the spectrum of TGD identities and how Blackness was defined in this study are fundamental for the focus of this study, Black TGD medical experiences. Research exploring Black TGD populations is lacking within Canada, though existing studies help provide insight to some of the issues relevant to Black TGD people's medical experiences. Ghabrial's (2017) study focused on how racism combines with homophobia and/or transphobia to create additional social challenges for Black and other racialized lesbian, gay, bisexual, transgender, queer, intersex, asexual, and Two-Spirit (LGBTQIA2S+) people. Ghabrial (2017) found some Black and other racialized LGBTQIA2S+ people were reluctant to disclose their queer identity to their ethno-racial communities, and this reluctance was thought to contribute to a decreased likelihood to seek medical care. This study also found Black and other racialized LGBTQIA2S+ people experienced microaggressions in addition to large-scale discrimination in many systems, including the medical system (Ghabrial, 2017). This study acknowledged that Black and other racialized TGD people are one of the most marginalized groups in society and noted that this population is often neglected in medical care and research (Ghabrial, 2017).

The TransPulse (2019) project, which was the first nationwide quantitative study of TGD Canadians, collected race-related data and asked questions specific to TGD people's medical experiences. The study revealed that Black and other racialized TGD people were less sure about pursuing, or planning to pursue, gender-affirming medical care even though they had similar access to medical care as non-racialized people (TransPulse, 2019). Black and other racialized TGD people also had lower self-reported overall health than non-racialized people (TransPulse, 2019), which could be due to medical racism or the lack of non-white providers. These are important points to consider, especially recognizing that Black patients tend to feel more comfortable and satisfied with care from a Black medical provider (Edbdalla et al., 2020; Etowa et al., 2007; Howard et al., 2019).

In the United States, Seelman et al. (2021) conducted a similar quantitative study using data from the 2015 US Transgender Survey to decipher patterns by patient race and ethnicity. They found that although Black and other racialized TGD people were less likely to have a primary medical provider than white TGD individuals, they were more likely to have experienced discrimination in a medical setting and were more likely to have been denied care (Seelman et al., 2021). Kattari et al. (2015), who surveyed TGD individuals in the United States to uncover experiences with various medical services, found that Black and other racialized TGD people reported higher levels of medical discrimination than white TGD respondents and experienced more transphobia across medical service settings than white respondents. Howard et al.'s (2019) study found that a main barrier to quality care for Black and other racialized TGD people was assumptions made by providers, which included assuming the patient's HIV status, drug use, sexual activity, or involvement in sex work. Additionally, providers assumed patients had less education and were less resourceful than patients of other identities (Howard et al., 2019). Some of these assumptions about education and health literacy may come from paternalism, or the concept of *doctor knows best* which may limit effective communication and the productivity of medical encounters (Alpert et al., 2021).

Howard et al. (2019) also found that TGD people of colour were reluctant to disclose their TGD identities for fear of discrimination and transphobia. While exploring medical discrimination, Seelman et al. (2021) found a significant association between being *out* as transgender to a medical professional and experiencing mistreatment (Seelman et al., 2021). A positive association was found between experiencing medical discrimination and suicide attempts and ideation (Seelman et al., 2021), which provides an example of the negative, even life-threatening, consequences of facing racism, transphobia, or both by a medical provider.

TGD Medical Experiences and Medical Terms

When examining Black TGD medical experiences today, it is essential to acknowledge that the historical treatment of TGD people within medicine has shaped current medical practices and experiences. Medical interventions, like gender-affirming hormones or surgery, are one aspect of the gender affirmation process for some TGD people. However, TGD communities have experienced numerous challenges within medical systems, including denial of care, cisnormative and binary gender research, and the pathologization of TGD identities (Casey, 2019; Johnson, 2018; Stryker, 2017; Colpitts & Gahagan, 2016). There is a vast history of the relationship between medicine and TGD people.

One particularly relevant piece of history is the evolution of the World Health Organization (WHO)'s International Classification of Disease (ICD) and American Psychological Association (APA)'s Diagnostic and Statistical Manual of Mental Disorders (DSM) which have pathologized TGD identities as a psychological concern (Johnson, 2018). In 1975, the ninth edition of the ICD was published and included the first diagnoses related to gender variance; *transvestitism* and *transsexualism* (Soll et al., 2018; WHO, 1975). This is thought to have marked the scientific acceptance that gender-variant people should not be subject to conversion therapy and led to consolidating however these terms and diagnostic criteria were pathologizing and were used to gatekeep care (Soll et al., 2018).

In 1992, the tenth edition of the ICD shifted to a diagnosis of *gender identity disorder* (GID), which employed a binary gender model and continued to pathologize wishing to change one's gender (WHO, 1992). In 2000, the fourth edition of the DSM recognized gender as a man-woman binary and classified the desire to change one's gender as a disorder (APA, 2000). In 2013, the fifth edition of the DSM removed GID, replacing it with *gender dysphoria*, which aims to recognize that having a different gender than one's sex assigned at birth is not a disorder (APA, 2013). It is important to note that not all TGD people experience gender dysphoria. Similarly, the updated WHO ICD-11 (2019) has replaced GID with *gender incongruence*, which similar to gender dysphoria, does not consider the desire to change one's gender to be a disorder. These changes from the APA and WHO signal how medicine, and psychology, have evolved over the years with regard to conceptualizing and categorizing TGD identities. There is a tension here, as the current medical model requires a diagnosis to initiate treatment, and although some TGD people today find engaging with current gender-identity-related diagnoses to be legitimizing or empowering, many believe it is not productive to include any diagnosis related to gender identity in the DSM or ICD because it continues to unnecessarily pathologize diverse gender identities (Johnson, 2018). The diagnostic criteria in the ICD and the DSM are used by many medical providers to restrict access to gender-affirming medical care while reinforcing binaries and hegemonic understandings of gender and failing to acknowledge the social and structural factors that contribute to dysphoria and discrimination (Casey, 2019; Johnson, 2018; Long, 2019). The methods through which language, including diagnostic labels, may perpetuate cisnormativity or pathologize diverse gender identities are explored in this study.

Another medical term that has been used within TGD communities is *body dysmorphia*. Body dysmorphia is a term that describes an obsession with a perceived flaw in one's appearance, causing significant distress (Mayo Clinic, n.d.). It is often tied to weight, and one's perception of their weight and body type (Mayo Clinic, n.d.). People with diverse gender identities may also experience body dysmorphia, however, this should not be conflated with gender dysphoria (Bushell, 2023).

Current TGD Medical Experiences in Nova Scotia

TGD people experience discrimination and barriers to accessing medical care in Nova Scotia. Particularly, there have been many barriers to accessing gender affirming medical care, some of which have been addressed, although many remain. Until July 2022, gender-affirming surgery applications in Nova Scotia had to include a letter of support from a Nova Scotia specialist and a letter from a specialist confirming post-operative care (Government of NS, 2022). It was not until community members advocated for change that the province recognized this as a barrier. Nova Scotia has now removed the need for a letter from a specialist (Government of NS, 2022). Due to the recognized barriers for LGBTQIA2S+ community members to access safe and quality healthcare, the Nova Scotia Health Authority has established PrideHealth to help LGBTQIA2S+ Nova Scotians access medical care. However, there are currently no tailored resources within PrideHealth, or information online regarding navigating the healthcare for Black LGBTQIA2S+ people, marking a lack of acknowledgement of the unique experiences of queer communities of colour within Nova Scotia. Thus, some barriers remain and there is no clear pathway for Black TGD people to access affirming medical care.

Within Nova Scotia, in addition to highlighting barriers to care, studies about the medical experiences of LGBTQIA2S+ people have found that medical language can be oppressive (Gahagan & Subirana-Malaret, 2018; Harbin et al., 2012; Vermeir et al., 2018). For example, the incorrect use of pronouns, and names can contribute to negative medical experiences for TGD individuals and can prevent them from seeking future care (Gahagan & Subirana-Malaret, 2018; Vermeir et al., 2018). Misgendering someone or *deadnaming* them can have significant negative impact on a TGD individual (Sinclair-Palm & Chokly, 2022). Deadnaming refers to using someone’s name given to them at birth, which in some cases is still their current legal name, with which they no longer identify with and is often indicative of a gender identity they no longer hold (Sinclair-Palm & Chokly, 2022). Medical paperwork and intake forms that do not use inclusive language with diverse options for sex and gender categories have also contributed to poor medical experiences (Gahagan & Subirana-Malaret, 2018; Vermeir et al., 2018). The language used to describe types of medicine can be harmful when it is not inclusive or, such as when people say, *women's care* instead of *gynecology* (Vermeir et al., 2018). Unfortunately, all studies previously conducted in Nova Scotia have had overwhelmingly white participants, which has not allowed for considerations of how race may impact medical experiences for TGD people (Gahagan & Subirana-Malaret, 2018; Harbin et al., 2012; Vermeir et al., 2018).

Within Nova Scotia, Vermeir et al. (2018) conducted a qualitative study which specifically explored white TGD adults' experiences with medical care. TGD adults reported feeling socially excluded within primary and emergency care settings, which was partly a result of interactions with medical providers (Vermeir et al., 2018). They stated medical providers should be positive, sensitive, and knowledgeable about trans health, which would help them build a strong patient-provider relationship (Vermeir et al., 2018). In fact, developing a strong relationship was identified as one of the most important components of a positive clinical experience (Vermeir et al., 2018). Establishing a positive relationship between patient and provider reflects the importance of language because specific words used by providers may signify the level of respect they have for a patient's identity and their needs. This may impact the trust the patient will have for their provider.

Medical Experiences of Black People in Canada

To unpack the medical experiences of Black TGD people, one must consider the historical treatment of Black people in Canada and how that impacts the present treatment of Black communities. Historically, biological differences of race were cited to justify slavery, and unsafe and unjust medical experiments were performed on enslaved Black people in Canada (Hassen et al., 2021). These historic practices have led to harmful myths and stereotypes about Black people that are still prevalent in the medical system today, including higher pain tolerance and lower intelligence of Black individuals (Dryden & Nnorom, 2021; Hassen et al., 2021; Sieroka, 2021). Stereotyping and medical bias toward Black patients is heavily reported in Canada (Dryden & Nnorom, 2021; Toronto Public Health, 2013), which have had significant negative impacts on Black people in Canada's disease burden and health outcomes because these issues lead to both poor quality care and avoidance of care (McGuire et al., 2020; Sieroka, 2021). In 2017, the United Nations issued a statement expressing deep concern about structural racism embedded in many Canadian institutions, including concerns for Black people in Canada's health outcomes as a result of systemic anti-Black racism (Dryden & Nnorom, 2021). Despite the exploration and documentation of medical bias throughout Canada, medical racism continues to negatively impact the lives of Black people in Canada (El Mowafi et al., 2021). Due to a lack of race-based data collection and data erasure, it is difficult to comprehend or quantify the scope and impact of medical racism on Black people in Canada, which also makes it difficult to measure the impact of interventions and create evidence-based solutions (Dryden & Nnorom, 2021; El Mowafi et al., 2021; Joshi, 2021).

Canada's current medical system poses barriers to quality care for Black patients due to historical and present-day examples of medical racism and violence toward Black people in Canada (Dryden & Nnorom, 2021; El Mowafi et al., 2021; Toronto Public Health, 2013). Medical providers may have conscious and unconscious bias against Black people in Canada, which negatively affects the care they provide (Toronto Public Health, 2013). These biases may impact how a provider interprets a patient's history, symptoms, and the risk or benefit of treatment. Due to the short nature of most clinical encounters, providers are more likely to draw from racial stereotypes (Toronto Public Health, 2013). This bias and discrimination likely contribute to the lower satisfaction with medical services that have been reported among Black and other racialized patients (Toronto Public Health, 2013). Black and other racialized patients have reported experiencing racial discrimination and a lack of cultural competence which can foster distrust in medical systems and can lead to avoidance of future care (Toronto Public Health, 2013). Hearing about or experiencing medical racism first-hand poses a challenge for developing positive patient-provider interactions and relationships due to mistrust on the part of the patient, and neglect or selective empathy from providers (El Mowafi et al., 2021).

Another factor impacting Black medical experiences in Canada is the lack of representation in the medical field. This originates from historically inequitable medical education policies, accreditation and governing bodies, and hospitals (El Mowafi et al., 2021). Patients have reported feeling more comfortable and receiving more competent care from Black providers (Howard et al., 2019; Etowa et al., 2017). Saied and Agbaire (2022) surveyed Black youth in Nova Scotia inquiring about social service use, and a section of this survey was dedicated to experiences with medical care. Respondents acknowledged that having a medical provider who did not look like them was a barrier to accessing competent services (Saied & Agbaire, 2022). Due to this racial dissonance, participants described that medical providers could improve their understanding of Black patients' needs to better serve Black communities (Saied & Agbaire, 2022).

Research on Black people's experiences with medical care in Nova Scotia has revealed that in addition to a lack of representation, there is also limited Black health training in the medical field. Nova Scotia Health (2021) published a report on racial injustice in the medical system and shared the experience of a Black patient who “was told by a health professional […] that [their] skin was too Black to be able to see the vein to draw blood” (p. 2). This quote is an explicit example of racism, exemplifies the lack of diversity in medical professionals’ training, and illustrates impactful language that has stuck with a patient. This quote also demonstrates that individuals beyond physicians, including nurses, phlebotomists, or other professionals, contribute to the medical experiences of Black people in Nova Scotia. The Health Association of African Canadians reiterated this concern when they asserted that Nova Scotia lacks culturally competent care for Black patients (Fraser, 2021).

Saied and Agbaire’s (2022) study shared participants’ experiences of racial microaggressions within medical appointments and the reproduction of harmful stereotypes about Black health (Evans et al., 2005; Etowa et al., 2017). One participant explained that hearing stories about current and past medical discrimination “jaded” them and made it difficult to trust medical providers (Saied & Agbaire, 2022, p. 11). Some participants reported medical discrimination and unfair treatment, and almost half of the participants stated they were unsure where to turn when they experienced medical discrimination (Saied & Agbaire, 2022), which may indicate a lack of reporting or resolving incidents of medical racism. In addition to overt discrimination, participants felt that their healthcare providers did not fully understand them or take their health concerns seriously (Saied & Agbaire, 2022). One participant stated that it felt as though their medical providers were too focused on their background or were distracted by their attempts to be politically correct (Saied & Agbaire, 2022). Some felt practitioners seemed surprised that they were asking questions about their health due to racist stereotypes about health literacy and education (Saied & Agbaire, 2022). Bias, discrimination, and a lack of diversity among medical providers and medical training contribute to negative medical experiences for Black people in Canada.

Although many Black people in Nova Scotia are descendants of historic African Nova Scotian communities, there are also large newcomer populations within Nova Scotia's Black population (StatCan, 2019). Anti-Black racism in medicine is further compounded by language barriers, culturally insensitive care, or other forms of discrimination in addition to access barriers (Kobayashi & Dent, 2019). This study remained open to the diversity among participants experiences with medicine based on these factors.

Gaps in the literature

Previous research on the medical experiences of gender diverse individuals in Atlantic Canada has looked more broadly at LGBTQIA2S+ communities and much of this research includes predominately white participant samples (e.g., Beagan et al., 2012; Gahagan & Subirana-Malaret, 2018; Harbin et al., 2012). Research devoted to non-white TGD communities in Nova Scotia is urgently needed, as the 2021 census has shown that Nova Scotia has the highest gender diversity in Canada among 15- to 34-year-olds (StatCan, 2021). This study investigates barriers that have been identified in previous studies, including provider discomfort, lack of knowledge, and issues with judgement (Beagan et al., 2012; Gahagan & Subirana-Malaret, 2018; Harbin et al., 2012; Vermeir et al., 2018) while filling a gap in the literature by focusing on provider language and Black TGD populations.

Despite the lack of research on Black and other racialized TGD people in Nova Scotia, previous studies offer a glimpse into TGD patients experiences in general. Vermeir's (2016) unpublished master's thesis looked specifically at transgender Nova Scotians' medical experiences, investigating their perceptions and experiences with both primary and emergency care. The study focused on aspects of clinic environments that impacted medical experiences and found providers' knowledge, attitudes, relationships, and language to be important facets of clinical encounters between transgender patients and their providers (Vermeir, 2016). Participants in Vermeir's (2016) study communicated that their providers perpetuated societal discourses surrounding TGD health as being "too niche" or TGD identity as a "choice" (p. 240). Language was not the focus of Vermeir's (2016) study, and my study addresses that gap by examining discourse in the context of Black TGD patient care.

Although no studies in Nova Scotia have examined the intersectional experiences of Black TGD populations, I used literature about the medical experiences of Black and other racialized populations in Canada, when necessary, and the United States, to contextualize my findings. For example, previous studies focused on racial health equity have uncovered a lack of comfort and trust with white providers, asserting that Black physicians are better equipped to care for issues unique to Black communities and would have more competent care approaches (Etowa et al., 2007). Other studies found that racism in medical appointments is often subtle as opposed to overtly discriminatory (Evans et al., 2005). Another study described how the "strong Black woman" trope originated from historic racist and sexist ideals and continues to be perpetuated by medical professionals and medical systems within Nova Scotia today (Etowa et al., 2017). Other studies have acknowledged the power of using language to name discrimination because it promotes accountability and contributes to the production of safe spaces (Hamilton-Hinch, 2015). My study explores provider language while investigating the needs and experiences of Black TGD patients. Overall, this study bridges conversations of racial health equity and TGD health equity to explore power imbalances and hierarchies and investigate how discourse impacts medical experiences for Black TGD people in Nova Scotia.

Summary

LGBTQIA2S+ Canadians and Black people in Canada have faced historic and current mistreatment by medical systems. Limited current literature is devoted to Black TGD populations, particularly focused on their medical experiences. As shown through a review of current literature, this project fills a gap in the literature by examining Black TGD patient populations to explore their medical experiences while focusing on how the language used by providers impacts clinical encounters.

Chapter 3: Methods

This chapter outlines the methodology for this study, including a discussion of the research approach and guiding theories. This chapter also explains key aspects of the research design, including the participant population and recruitment strategies. Data collection instruments and data analysis strategies are stated. Finally, ethical considerations and comments on data quality for this study are discussed.

Research Approach

This study used a qualitative approach to explore how language impacts the experiences that Black TGD patients have with medical professionals. A qualitative approach emphasizes participants' experiences and views, explores the meaning individuals or groups attribute to a social phenomenon, and helps uncover multiple contributing factors to participants' experiences (Creswell & Creswell, 2019; Pope & Mays, 1995). Qualitative approaches also give participants the ability to freely express their opinions and experiences (Creswell & Creswell, 2019). Considering this study's focus on language, a qualitative approach allowed participants to describe the meaning and effect of language on their experiences with medical professionals.

Qualitative research has become more important within the medical field, as explorations of specific patient populations has become necessary to support the expansion of quality health service provision (Pope & Mays, 1995). Thus, a qualitative design provided a valuable approach to explore Black TGD people's experiences and contributes to the growing field of qualitative research focused on medicine.

Conceptual and Theoretical Framework

This study was guided by a social constructionist paradigm and employed Black trans feminism. In the following sections, I outline the key conceptual and theoretical approaches underpinning this study while explaining how these frameworks will enrich my research.

Social Constructionism

Research paradigms refer to a set of philosophical assumptions that guide the researcher's thought process and analyses (Mertens, 2010). This research is grounded in a social constructionist paradigm; thus knowledge, discourse, and identities are seen as dynamic entities with their meaning being dependent on their context (Burr, 1995). Social constructionism urges researchers to question assumptions, critique societal norms, and unpack how we commonly understand the world. Social constructionists acknowledge and highlight how discourse contributes to the construction of categories and how the categories and discourses that are prevalent in society are historically and culturally specific to that context (Schudson & Gelman, 2023). Social constructionists emphasize that categories stratified by power, like gender or racial categories, are produced through language and actions which continually define and reinforce said categories (Schudson & Gelman, 2023).

Through social constructionism, knowledge is understood as being constructed and sustained between people through social processes (Burr, 1995). This view helps posit the medical encounter as a site through which knowledge is shared and contested based on societal and cultural norms. This lens also helped reveal how my own knowledge and perceptions are based on my lived experiences and culture which impacts the way I see the world.

When framing participants experiences, I used the social constructionist understanding that there can be more than one construction or interpretation of an experience, and that this construction may be subject to change with time and other contextual factors (Guba & Lincoln, 1994). The social constructionist paradigm allows researchers to situate participant's experiences using relevant social, historical, and cultural factors that may influence their interpretations (Burr, 1995).

Like experiences, identities can also be seen in this manner, acknowledging the dynamic nature of one's gender or racial identity, and the social construction of these categories (Burr, 1995; Lorber & Moore, 2002). Social constructionism can be used to unpack how certain identities impact medical experiences and overall health. There is a popular saying, for example, that "women get sicker, but men die quicker" which is supported by epidemiology and is indicative of the social construction of illness (Lorber & Moore, 2002, p. 13). Race, sex, and gender are significant determinants of health which impact social, environmental, and physical factors that have cumulative effects on medical experiences and overall health (Etowa et al., 2007; Hudson, 2019). This impacts differences in health outcomes like the incidence of chronic disease and the length of life expectancies as well as medical interactions, such as the likelihood of a medical provider to order further tests to investigate symptoms or health complaints (Hudson, 2019; Lorber & Moore, 2002).

For those of multiple identities that have been marginalized, these are not seen as isolated entities but instead can be understood using the social constructionist paradigm that Patricia Hill Collins (1990) named the *matrix of domination.* This matrix of domination is used to view how multiple subjugated identities converge to construct lived realities for groups like Black TGD people (Hill Collins, 1990). This made social constructionism a natural paradigm for this thesis project because of the population of focus, Black TGD patients. Social constructionism also aligns with thematic analysis and

Black trans feminism as these each value listening to lived experiences and exploring how systems, structures, and societal factors influence these perspectives.

Social constructionism was also useful for this study to critique medical practice and medical institutions. The discourses medical professionals choose to employ can be viewed as an indication of ideals within the medical community and broader societal norms. Additionally, medical knowledge, research, and education can be seen as constructed by normative discourses and the lived experiences that medical professionals themselves bring to their work (Lorber & Moore, 2002; Rodríguez et al., 2022). Social constructionist approaches were used within this study to unpack normative assumptions and discourses to reveal broader medical and social implications.

Black Trans Feminism

Similar to social constructionism, Black trans feminism (BTF) is aimed at unpacking social conditions and the construction of identities. BTF, which uniquely bridges Black feminism and trans studies, was a guiding theory for this thesis. Although this theory formally unites Black feminism and trans studies, these areas of study have always been interrelated. Che Gossett stated Black feminism is "always already trans" while referring to the fact that Black feminism has worked to interrogate the meaning of the label "woman" and to broaden male dominated understandings of Blackness (Hayward & Gossett, 2017, p. 18). Historically, people have defined womanhood in a way that restricts access to Black women, trans women, and other groups. Black feminism has always been concerned with broadening these definitions and focusing on how systems of power work to reinforce socially constructed racial and gender categories (Green & Bey, 2017; Snorton, 2017; Taylor, 1998). Gender and race have been explored by Black feminist scholars like Moya Bailey (2016), who coined the term "misogynoir" to describe the unique union of anti-Black racism and misogyny that Black women experience.

Like Black feminism, trans studies focus on gender categories while examining how differences in sex and gender relate to social hierarchies (Stryker & Whittle, 2013). Normative trans studies emerged in the 1990s bridging feminism and queer studies (Stryker & Whittle, 2013). Importantly, Black feminism and trans studies are not separate phenomena that serve mutually exclusive populations, but instead can be understood as liberatory approaches aiming to better serve all groups that have been marginalized (Green & Bey, 2017).

Many scholars have pointed out the benefit of Black feminism and trans studies embracing one another to broaden their scope. Ellison et al. (2017) and V Varun Chaudhry (2020), for example, have asserted that trans studies need Black feminism. Chaudhry explained the benefit of Black feminism in expanding the focus of trans studies to better recognize and understand how (trans)gender is, and has always been, "racialized and reliant upon (anti)Blackness" (p. 530). Chaudhry (2020) cites Snorton's (2017) work, explaining that trans identity and trans studies must recognize the fungibility of gender that enslaved Black people experienced. Snorton (2017) told the story of many enslaved Black people who crossed gender binaries and leveraged this fungibility to open possibilities for freedom and liberation. Recognizing historic and current structural factors hindering Black lives might allow trans studies to better represent the lived realities of trans people (Chaudhry, 2020).

Black feminism and trans studies come together under similar guiding principles that examine, reject, and reimagine societal norms that favour and uphold dominant identities in society. Both areas of study urge researchers to question and unpack assumptions to see how these serve the interests of particular groups and reinforce their power in society and institutions. Black feminism and trans studies both aim to create more inclusive and accurate terms and labels that account for diverse populations.

By bridging Black feminism and trans studies, BTF aims to break down hegemonic assumptions about race, sex, and gender to theorize how power relates to these identities (Bey, 2022). BTF recognizes how power produces the identity options (or non-options) available to people, shaping the way gender is understood and assessed. BTF acknowledges the coercive nature of the gender binary and views transness as non-normatively related to this binary (Bey, 2022).

BTF strives for opacity, which is a dynamic understanding of one's positionality as various identities dynamically converge (Bey, 2022). BTF is interested in the unfixing of identities, which requires letting go of current power structures to gain insight as to how we may move forward in a way that better serves those of identities that have been marginalized (Bey, 2022). Explorations of power reveal how whiteness and white scholarship dominate and serve to erase Black queer and trans theoretics and experiences (Hull et al., 1982).

In this study, I used BTF to examine participants' experiences within medical appointments to deconstruct identity negotiations and normative assumptions. BTF facilitated a deeper reading to recognize and name medical structures of oppression while imagining a future of medicine that serves diverse patient populations. BTF scholars have identified various harmful societal norms like "perinatally designated sex and gender, or White supremacist epidermalization of value, or cis male supremacist subordination"

(Bey, 2022, p. 14). Within medicine, children are assigned sex and gender before or shortly after birth as if sex and gender are synonymous and gender identity is fixed. Medical practices like this should be examined through BTF lenses to ensure accuracy and openness to dynamic identities. White supremacist epidermalization of value, or epidermalization of the inferiority of Black people, refers to the way that racialized people experience their sense of being through other's perceptions (Bey, 2022). This marks a disassociation between the self and the world often experienced through the skin, in which the outer layer is called the epidermis (Allan, 2022). Black trans feminism can be used to explore how Black TGD patients experience their sense of being in medical spaces, and how perceptions of medical providers of different identities may influence this. White cis male supremacist subordination of others can also be employed in medical settings to examine power imbalances with Black TGD patients.

BTF recognizes whiteness and cis genders are not normative due to majority status but because they have been represented as valid and normal, framing other identities as imperfect or deviant (Bey, 2022). This study highlights Black TGD experiences within a medical system that normalizes whiteness and cisgender identity and used BTF to unpack assumptions related to identity and language about identity within medical appointments.

Framing Discourse and Power

Language

Using social constructionism, I have come to an understanding of language as reflective of sociocultural norms and individual beliefs, while being subject to resistance and capable of change. Through social constructionism, words can be seen as "symptoms of the culture that produced them" (Downing, 2013, p. 93). As such, identities are constructed through the language that is present in a certain culture which is shaped by the prevalent discourses of gender, sexuality, race and other identities (Burr, 1995). This notion may help one understand why medical providers use certain language or how patients interpret certain language. When considering the meaning of language, it is important to note that this meaning is not necessarily universally true (Miller, 1990). The meaning behind language is inherently subjective thus may differ from person to person and may depend on one’s life experiences, identities, or culture (Miller, 1990). Additionally, discourses are capable of change and are not monolithic. Language is always contested by other discourses through resistance and change (Burr, 1995). For this study, it is important to understand that the meaning behind certain language may be subject to change over time, across cultures, and between individuals. Additionally, there is hope that language practices can be improved through awareness and education.

Power

To theorize an understanding of power for this project, I used social constructionism and Black trans feminism to understand how labels and terms can uphold power imbalances, construct identities, and impact identity negotiations. Social constructionists argue that to fully understand societal power imbalances, discourses that create and uphold particular forms of social life must be examined (Burr, 1995). This understanding was useful to unpack norms that supported power imbalances in clinical encounters.

Social constructionists contend that labels, terms, and other representations of people, for example “masculine” or “well-educated,” can serve to maintain or advance power imbalances between individuals, while framing these power inequalities as inherent and natural based on these representations or identities (Burr, 1995, p. 42). One method of exercising power is by defining a person, an identity, a group, or the world in general in a way that affords you privilege (Burr, 1995). An example of this is to categorize people as “mad” and others as “sane” which creates power inequities between these groups (Burr, 1995, p. 42). This is especially relevant when examining medical provider’s language use and medical terms that have impacted TGD people’s access to affirming care. BTF works to reveal medical structures of oppression and reimagine the medical field to be more inclusive and affirming (Bey, 2022). BTF also encourages unfixing identities to let go of current power structures that fail to serve the needs of populations that have been marginalized (Bey, 2022). In terms of gender, BTF also reveals how power acts on us to construct understandings of our own gender and the gender of others which produces the gender options or non-options available to an individual (Bey, 2022). All of which are useful notions when exploring Black TGD medical experiences.

Method of Analysis

In addition to Black trans feminism and social constructionist theories, this study employed thematic analysis to analyze the data from semi-structured interviews. I explain this method of analysis below.

Thematic Analysis

Thematic analysis is a qualitative method known for its flexibility and accessibility (Braun & Clarke, 2006). It can be used with a variety of theoretical approaches to identify, analyze, and report patterns within qualitative data (Braun & Clarke, 2006). Thematic analysis allows for rich descriptions of qualitative data while presenting findings in an accessible format (Braun & Clarke, 2006; Braun & Clarke, 2014).

Within research focused on language, thematic analysis has proven useful in linking everyday discourse to broader norms and ideologies (Lawless & Chen, 2019). Thematic analysis has been particularly useful to highlight perspectives from communities that have been marginalized and to relate such identities to hegemonic societal structures and ideologies (Lawless & Chen, 2019). Thematic analysis identifies patterns in data and can therefore be used to identify common experiences and further understand and share the realities of groups that have been marginalized (Lawless & Chen, 2019). These realities can be examined to identify power influences and dominant structures which can allow the envisioning of new ways to communicate that are conscious of identity-based hierarchies, power imbalances, and marginalization (Lawless & Chen, 2019).

In the 1970s, thematic analysis first appeared as a research method yet specific guidelines for its use were not made explicit until 1998 (Braun & Clarke, 2014). Boyatzis (1998) published a text laying the groundwork for thematic analysis, with a focus on coding and theme development (Braun & Clarke, 2014). Thematic analysis, put simply, involves assigning codes to data and organizing said codes into themes, or patterns among participant responses (Braun & Clarke, 2006; Boyatzis, 1998). Boyatzis (1998) described a theme as a pattern found in the data that may act as a description of observations, an organization of different observations, or even an interpretation of aspects of the topic at hand.

Thematic analysis gained traction in social and health sciences following Braun and Clarke’s (2006) article that explained the use of thematic analysis in psychology (Braun & Clarke, 2014). Since the publication of this foundational text, thematic analyses have been used in the United States to explore TGD people of colour's healthcare experiences (Abreu et al., 2022), perceptions of community resources (Gonzalez et al., 2022), and resilience (Ruff et al., 2019). Within Canada, thematic analysis has been used to explore coming out experiences of LGBTQ+ people of colour (Leung, 2021), normative ideals in queer communities (Logie & Rwigema, 2014), and the invisibility of bisexual and gender diverse people of colour (Ghabrial, 2019). Within this study, thematic analysis was be used to examine themes among participants' experiences with medical care, thereby allowing for an exploration of how social norms are created and maintained, how personal and group identities are constructed for Black TGD patients.

Interview transcriptions were coded using NVivo software following Braun and Clarke's (2006) six-phase approach to guide the thematic analysis process. Phase 1 involved getting familiar with the data by transcribing, reading, and rereading the data while writing out initial thoughts and ideas (Braun & Clarke, 2006). In phase 2, initial codes were generated by systematically coding features of the data and collating relevant data for each code (Braun & Clarke, 2006). In phase 3 codes were organized into potential themes, collecting all data relevant to each theme. Phase 4 involved reviewing themes to check if they relate to and reflect the coding extracts and the entire data set while creating a thematic map (Braun & Clarke, 2006). In phase 5, themes were refined until they were able to be clearly defined and named (Braun & Clarke, 2006). Phase 6 involved writing the findings which included selecting excerpts from each theme, and ensuring the final analysis was related back to the original research question and the broader literature (Braun & Clarke, 2006).

Thematic analysis was used as a social constructionist method to examine how interactions, realities, meanings, and experiences result from the range of discourses operating within society (Braun & Clarke, 2006; Burr, 1995). Social constructionist thematic analyses look beyond individual psychologies to theorize the wider sociocultural contexts, power structures, and systemic factors contributing to the perspectives shared (Braun & Clarke, 2006). Thematic analysis was used at the latent level to go beyond the data to examine the ideas, assumptions, and ideologies behind what was said. The extracted themes both described and theorized the underlying power structures and meanings within the data (Braun & Clarke, 2006). These theories were driven by BTF which aligns with social constructionist perspectives because both can be used to question hegemonic assumptions and explore the ways identities are socially produced. Theoretical thematic analyses analyze sections of the data in rich detail, instead of recounting a broad description of the overall data (Braun & Clarke, 2006). Using social constructionism and BTF, power structures were identified and reimagined while exploring Black TGD people's experiences and perspectives.

Participants

To examine how language impacts the experiences that Black TGD people have with medical care in Nova Scotia, I conducted semi-structured interviews. There were criteria for participation, namely that participants had to: 1) speak English, 2) identify as transgender or gender diverse, 3) identify as Black, 4) have lived in Nova Scotia for at least one year, and 5) have received medical care from a medical provider in Nova Scotia within the last five years. For the purposes of this study, "medical care" included primary and/or emergency care from a medical provider, including physicians, nurses, and other healthcare workers, and was not limited to trans-related care. Due to the exploratory nature of this study and the relatively small population of Black TGD people in Nova Scotia, I recruited four participants. This sample size allowed me to explore Black TGD people's experiences from multiple perspectives while adhering to a realistic time frame for recruitment, analysis, and the writing of the final thesis.

Time Commitment and Compensation

Participants were compensated through funding from a Canada Graduate Scholarship from the Social Sciences and Humanities Research Council (SSHRC) as well as a Student Award from the Maritime Strategy for Patient-Oriented Research Support Unit. Specifically, participants received a $50 Visa gift card for completing a 45-minute interview.

Recruitment

This project received ethics approval on November 10, 2022 (REB # 2022-6350). I began recruiting in mid-November and interviewed my final participant in mid-March 2023. To recruit participants, I utilized direct and respondent-driven sampling. Although there are concerns associated with the limitations or homogeneity of this recruitment method, some scholars have argued this is the ideal method available when attempting to reach smaller communities that may be hesitant to engage with academic research (Ellard-Grey et al., 2015). This technique helps reduce the amount of time and funding necessary to complete recruitment, thus making it a feasible method for graduate student researchers (Ellard-Grey et al., 2015). To engage Black TGD individuals, I used existing relationships I had with trusted community organizations that work with Black TGD people. These individuals shared contacts that might be interested in participating or might know others that may be interested in participating. This provided me with an initial sample of participants and more contacts to reach out to about prospective participants. I was then able to ask these individuals to refer or recruit peers, which is also known as snowball sampling (Ellard-Grey et al., 2015). When discussing recruitment, and the challenges doing so in smaller communities, it is important to identify and name the mistrust within many communities to participate in research that stems from real exploitation and a lack of diverse researchers. It is necessary to be aware of this mistrust and to make a concerted effort to make genuine connections and rebuild confidence in research.

Data Collection

Screening Survey

Individuals who were interested in participating in the study were asked to complete a short screening survey to ensure they met eligibility criteria. This took no more than five minutes and determined potential participants' eligibility. The screening questions were sent via email. Eligibility was determined by asking potential participants if they identify as TGD and Black, their age, how long they have lived in Nova Scotia, if they speak English, and the last time they saw a medical provider. Potential participants who completed the screening survey were notified via email of their eligibility status. All participants who completed the screening survey were deemed eligible and were sent additional information about the study and a consent form. The consent form informed participants that they could withdraw from the study at any point during the interview, and up to one month after the interview date. This allowed a window to withdraw from the study before data analysis had concluded and written reports of the findings commenced.

Interview

Each interview lasted between about 40 minutes and one hour. The interview guide (Appendix A) was used, which expanded on themes uncovered in my literature review and addressed gaps in the current research. In the interviews, I also asked participants for their pronouns and if they would like to choose their pseudonym for the written thesis.

Interviews were conducted in person, on Dalhousie campus or via Microsoft Teams, according to the participant's preference. Interviews were recorded using Teams and via an iPhone audio recorder, which was made clear in the consent forms and confirmed before beginning the interview. After each interview was completed, I transcribed the recordings myself. Once I ensured the transcription was accurate, I deleted all copies of the audio recordings.

Ethical Considerations

Although this project posed minimal risk to participants, there are important ethical considerations that were addressed. These considerations included informed consent, participant vulnerability, confidentiality and anonymity, and potential harms and benefits for participants.

Informed Consent

In the consent forms, participants were informed about how their interview responses would be included in the study. The consent forms explained the participant’s ability to withdraw from the study before their interview, during their interview, or up to one month after their interview had been completed. The forms also included contact information for myself, my supervisor, and the university ethics board in case they wanted to pose questions, share concerns, or provide comments.

Participants were encouraged to ask any questions they had at any point before, during, or after the interview, and were made aware of their right to skip any questions they preferred not to answer. The consent forms explained that direct quotes, without identifying information, would be used in the written thesis and attributed to a pseudonym of the participant's choosing. Consent forms outlined the honorarium that participants would receive after the completion of their interview.

Overall, the consent form addressed ethical considerations by informing participants of their rights with regard to their participation in the study, how their confidentiality would be held and maintained, contact information in case they had concerns or questions about the study, and mental health resources if needed.

Participant Vulnerability

I am aware that the topics of this research project, discriminatory and harmful medical experiences, could have brought up negative emotions among my participants. Mental health resources were provided in the consent forms, including Canadian helplines and regional mental health services dedicated to LGBTQIA2S+ communities and Black people. By providing such resources, I aimed to promote participant comfort and safety and, in doing so, help ensure that participants received support if/when they experienced negative emotions during or after their involvement in this study. Additionally, to increase comfort, I shared a bit about myself at the beginning of each interview, including my interest in this topic and my own identity as a biracial cisgender woman.

Confidentiality

Audio recordings from the interviews were stored on my personal password-protected cell phone and computer. Once recordings were transcribed, all identifying information was coded. Participants were assigned an interview number from P1 to P4, which was later replaced by the pseudonym of their choice, so no identifying information was used in the written report. I was the only person with knowledge of these codes and pseudonyms. All interview and survey data, participant contact information, and notes were stored and analyzed on my password-protected computer, and no hard copies of the interview transcripts or handwritten notes were produced. I was the only person with access to these passwords. All digital notes from the interviews and interview transcripts will be deleted once I have successfully defended my thesis. Participant contact information will be saved securely on my password-protected computer to follow up with participants once the findings are ready to be disseminated. Though pseudonyms have been used with direct quotations in this thesis, quotes that included demographic information or other potentially identifiable information were edited to ensure participant confidentiality and anonymity.

Potential Harm and Benefits

This study is considered of minimal risk to participants in that the potential harms associated with participation are "no greater than those encountered by participants in those aspects of their everyday life that relate to the research" (TCPS, 2018, p. 22). Given the sensitive and personal nature of the topics covered in the interviews, it was possible that participants' recollections of past memories might have brought up negative emotions. Mental health resources specific to LGBTQIA2S+ communities and Black people in Canada were highlighted in the consent forms. Participants were also reminded of their right to avoid questions that they did not feel comfortable answering. These efforts were meant to minimize any potential harm that participants may have experienced and to support them during/after the interview in case they needed resources.

I informed participants about the value of sharing their experiences and perspectives. For example, some of the benefits to participants include being given a platform to share their experiences while contributing to a study that aimed to improve patient-provider interactions for Black TGD populations. Participants might have found value in contributing to a study highlights the medical experiences of Black TGD communities and may offer information that could be used by providers and others in the fields of health and medicine.

Data Quality and Trustworthiness

Credibility, transferability, dependability, and confirmability are important aspects of data quality and trustworthiness for qualitative researchers to consider (Mertens, 2010). I worked to improve credibility by ensuring all claims were clearly supported by the data and providing transparency for data analysis (Mertens, 2010). Consultation with thesis committee members and researcher reflexivity further contributed to this study's credibility (Birt et al., 2016; Mertens, 2010). Specifically, my master's committee includes queer, trans, and Black researchers who provide input on the project. Participants also had the opportunity to provide feedback during the interview and to suggest topics that were not covered by the interview guide.

Transferability is associated with the ability of research findings to be transferred to various contexts (Mertens, 2010). This study aimed to provide detailed descriptions, including contextual information, to encourage critical reflection on project findings and consideration of how findings can be transferred to other contexts (Mertens, 2010).

Dependability concerns whether the study can be repeated to yield comparable results (Mertens, 2010). Transparency throughout the research process and detailed descriptions of the context of this study and its participants aimed to contribute to the dependability of this study.

Confirmability refers to the findings and interpretations in a project being grounded in the data as opposed to being created by the researcher (Mertens, 2010). I aimed to demonstrate how interpretations were drawn using specific evidence from the data and critically reflected on my own research practices to consider if, and how, my biases may have influenced the study.

Summary

This project applied thematic analysis to conduct a qualitative study with a theoretical foundation of Black trans feminism and a social constructionist paradigm. This project recruited four Black TGD people in Nova Scotia to participate in semi-structured interviews that investigated the language used by medical providers and how this impacted patients' experiences with medical care and, consequently, their overall health. I used thematic analysis to analyze interview transcriptions to uncover structures of power and oppression as reflected in provider language. As the researcher, I aimed to provide rich contextual data while prioritizing transparency throughout my research, and continually reflect on and scrutinize my own biases to uphold high standards of data quality and trustworthiness. Overall, this project examined how the meaning of language is perpetuated and how this impacts the experiences of Black TGD individuals in medical contexts with attention to broader sociopolitical factors.

Chapter 4: Findings

This chapter begins by providing a summarized description of the participants who were involved in this study. The following sections address the central research question for this study: How does language impact medical experiences and quality of care for Black TGD people? While addressing the sub-topics; affirming language, non-affirming language, identity negotiations, and medical terms and education. Communication and language from medical encounters as recounted by the participants is presented and examined to assess how this language impacts the medical encounter. The following themes represent important components of medical interactions as described by Black TGD people in Nova Scotia: *Barriers to Care, Assumptions and Non-affirming Language, Affirming Language, Provider Identity and Communication Style, Medicine: Medical Terms, Medical Education, and Medical Training*. These components all impacted comfort levels, quality of care, and trust for Black TGD patients.

Participants

Four individuals took part in this study through semi-structured qualitative interviews. At the start of the one-on-one interviews, each participant was asked to introduce their name and age and describe their gender identity and racial identity. All of the participants were English speaking, identified as transgender or non-binary, and were at least 18 years of age. One participant was between the ages of 18 to 22, two were between the ages of 23 to 30, and one was over 30 years old. All participants were living in the Halifax Regional Municipality at the time of the interview. Some had previously lived in rural Nova Scotia and Toronto. One had moved from the Caribbean to Canada at a young age. Although not directly asked, participants spoke of their employment in areas spanning from the veterinary field, web development, youth work, and addictions. At the time of the interview, all of them had lived in Nova Scotia for at least two years and had experienced some form of medical care in Nova Scotia during at least the last five-year period. The emphasis was on current medical experiences; however, participants were free to share any previous medical experiences as long as they provided context. At the end of the interview, participants were asked to select a pseudonym to be used within the thesis.

My first participant, Elle, described herself as a Black woman of Nova Scotia. She has different ethnic backgrounds, but she has not tapped into them. She further described herself as being an "AMAB transgender societal cis-presenting woman."

My next participant, Isaiah, explained that they identify as African Nova Scotian because their entire family is from Nova Scotia. They also identify as non-binary, using they/them pronouns, and explained their journey and experiences with this identity.

> Growing up, I felt a lot of pressure and responsibility to uphold the gender that was placed on me. And that came with a lot of negative connotations that I did not enjoy, and I realized that, like me being my authentic self meant removing myself from a label that had all this association with how much I should be a man and masculine. […] Being a non-binary person without any of those roles to uphold, feels really awesome.

Another participant, Seb identifies as "Black and non-binary" and uses they/them pronouns.

My last participant, Mae, identifies "firstly as Black." They are biracial but people "mostly perceive [them] as Black," and they describe their gender as non-binary and fluid, explaining “I experience days where I feel more masculine or more feminine.” They use they/them/he pronouns.

Barriers to Care

The first theme that was extracted from the interviews was related to access to care and willingness to seek care. Within the interviews, participants discussed their frustration with wait times and general challenges accessing medical care within the province. Participants described language used by medical providers that denied or gatekept care, reinforced the gender binary, and imposed cisnormative ideals onto TGD identities. Participants explained that these negative experiences led them to be reluctant to disclose TGD identities or reluctant to seek medical care in general.

Denial of Care

Many participants spoke of being denied medical care from providers based on appearances or identity. They reported that some providers claimed to lack knowledge or claimed they did not want to offend the patient. Participants also said that other providers denied access to gender affirming care and sex-related health screening, and they talked about more general concerns like pain medications or other diagnoses and treatments.

Elle shared many specific experiences of being denied care. She recounted a physician once saying “no” to providing care for her when she was waiting at a walk-in clinic. She said this physician did not have any medical charts or background information on her “so they were purely going on just looks” and denying care based on their evaluation of her appearance. Elle also shared some of the specific excuses that providers communicated when denying care. She said medical providers have used her weight and her ethnically diverse background as reasons that make it “complicated” for her to take estrogen. She shared that some providers may sound as if they are saying, “I don't want to harm you," when what they are actually saying is, "I don't have the time or the patience to be able to deal with it." Here, Elle reads between the lines to decipher what her providers might mean when using this language.

All participants spoke about long wait times for primary and emergency care, and many noted how this led to frustrations when care was denied after waiting so long to receive it. Mae Seb, and Elle spoke specifically about waiting and then being denied gender affirming medical care, sex-related screenings, pain medications, and diagnoses. Mae recalled that providers in the emergency department had told Mae that they "don't know enough about [their symptoms] to do something." Mae stated "it's just frustrating" when medical professionals "can't provide me any sort of effective care" especially when there are existing access barriers within the medical system.

Barriers to Receiving Care

The participants explained experiences where they felt providers were gatekeeping gender affirming care through language that perpetuated a false idea of what it means to be trans "enough" to need gender affirming care. Participants also commented on the language some TGD patients might use in an attempt to convince providers they are trans "enough," like enhancing their discomfort, and other factors that impacted their ability to access gender affirming care.

Elle described an experience she had when attempting to begin her medical transition about a decade ago.

> Back then, it was like, if you're gonna transition, you have to look and act like a woman. […] That is the biggest effing thing when it comes to medical professionals is gatekeeping. "Well, if you don't lose a certain weight or if you don't look this certain way, if you don't act a certain way, if your mental health is

> not this certain way, then we're not going to help you." And they use it as gatekeeping.

These notions that one must look or act a certain way to be trans "enough" to medically transition are still seen and experienced today. Mae spoke of these same guiding principles physicians use, claiming patients' must feel a certain way to "really need" gender affirming care while sharing their experience as a non-binary person seeking top surgery to affirm their gender. Mae stated:

> The uncomfortable assumption that if you're going to get surgery or hormone treatment therapy or anything that you must […] really make it seem like you are so uncomfortable in your body and you hate your body which is not the truth for all trans people.

They went on to explain that some TGD people want to feel more comfortable in our bodies but that does not always mean they are experiencing "inescapable body dysmorphia." Medical providers have the power to withhold care from those that do not appear to fit within this one experience of TGD identity. Due to this, Mae said that they heard of many people adjusting their stories to meet the expected narrative of gender dysphoria. Mae urged doctors to listen and believe TGD people.

> [J]ust believe trans people for what they say they're experiencing and like who they want to be and how they're trying to connect with themselves and who they are.

Mae spoke of gender diverse people tapping into a specific narrative or having "to beef up their stories or make their experience sound more painful" to be seen as valid in their request for gender affirming care. Mae continued to share, “I was basically told like I'm not miserable enough to access the care that I want.”

Reluctance to Disclose

When discussing barriers to care, the topic of disclosure came up. Participants explained that intersecting identities, the ability to pass as cisgender, and the relevance of their identity to the medical care they were seeking all contributed to their decision to disclose or not in medical settings.

Hearing about the experiences of others can influence other Black TGD people to refrain from disclosing. Isaiah discussed how hearing from others that unless they were seeking hormones from their doctor “then talking to them about gender identity complicates the process.”

At the interview, Isaiah explained that they were not seeking gender affirming care, so until they feel their identity is relevant to the care they receive they are not thinking of disclosing their gender identity.

Elle explained a similar reluctance, sharing that although she has a confident and upfront nature, she found it difficult to disclose her trans identity due to the intersecting identities and factors impacting the way others, including medical providers, treat her.

> [T]here had been times […] when I started my transition […] that, I didn't want to tell people because like I'm already Black and I'm already an overweight person and I'm already in the queer community, you know? […] Do I wanna add this all onto it?

Mae noted the privilege some TGD people have in being able to avoid such conversations if they choose to.

> I have the privilege as somebody who is not transitioning to the other side of the binary. I can pass I guess, not everybody can pass, and I can't imagine like how much harder that would [to] be asked all kinds of questions about who you are.

Reluctance to Seek Care

When asked if a past medical experience had ever made the participants reluctant to seek future medical care, all participants said yes. Participants spoke of excessive wait times, constantly feeling like they had to defend themselves, and facing discrimination or denials of care.

Isaiah shared that they typically having long delays for scheduled appointments with their family doctor, which was a factor contributing to their reluctance to go to the doctor. They stated, “if I don't have up to like a 3-hour time span then I can't go to the doctor.”

Elle also brought up discouraging wait times, citing that she did not have the time to wait 6 and a half hours to receive care in the emergency department. She went on to explain that she has to be experiencing an extreme emergency to actually go to the emergency room.

> [I]f my doctor's not available […] I'm not gonna go and put myself through that to be misgendered, belittled, or talked down to. […] If you're constantly having to defend yourself or like, you're not getting the care you need. And you might not even go back too because I've had some really bad experiences with medical professionals.

Elle explained that Covid-19 and the lack of primary care physicians in Nova Scotia have both contributed to the need to use emergency services, which many Black TGD people may be hesitant to use.

Seb mentioned their experience being initially denied treatment in the emergency department and then receiving "different instructions from different people" about their treatment plan. This led to a frustrating and confusing experience that made them reluctant to seek future care. Not feeling heard, comfortable, or confident in the care they received contributed to Seb's desire to avoid the medical system in the future. Long wait times, invalidation, and feeling unsatisfied with care, or lack thereof, have led participants to be reluctant to seek future medical care.

Assumptions and Non-Affirming Language

This section introduces the next two themes: assumptions and non-affirming language. The explanation of these themes continues to address the central research question, by offering examples of the communication of assumptions, or the use of non-affirming language and how these impacted medical experiences. When prompted to describe negative experiences in medical settings, participants shared how the communication of assumptions and the use of non-affirming language by providers led participants to feel disrespected, frustrated, overlooked, and not valued.

Assumptions

The participants cited many examples of the assumptions that medical providers communicated to them, such as assuming cisgender identity, heterosexuality, or race as biological. Other assumptions that the participants mentioned included that the patient is involved in sex work, uses recreational drugs, or that the "doctor knows best." The communication of these assumptions led to a lack of comfort for participants and diminished trust in the medical care they were to receive.

Cisnormativity and Heteronormativity

Participants shared that their medical providers often made assumptions that perpetuated cisnormativity and heteronormativity. Examples included medical providers assuming cisgender identity, reinforcing the gender binary, and assumptions of pregnancy. Seb and Mae both shared that they are often assumed to be cisgender in medical settings. Seb went on to explain that for these assumptions to stop providers need to "be open that the person you see in front of you may identify differently than you assume." Seb believed this would improve medical providers' language and communication.

Elle, Seb, and Mae also shared experiences where cisnormative assumptions were made about their reproductive organs, or heteronormative assumptions were made about their sexuality, and the possibility of pregnancy. Elle shared experiences like being asked incessantly about whether she is pregnant and being questioned about having hot flashes due to her gender affirming hormones.

> "Are you sure you're not pregnant?" "Yes." "Are you sure you're not pregnant?" I'm like, "listen, if I'm pregnant, Oprah's coming out of retirement." […] Another thing that I get made fun of for a lot is having hot flashes […] because of the estrogen that we take. And people are like, "Wait a minute, you're only in your 30s, how are you having hot flashes?" So, I have to kind of explain because of the estrogen and then there comes to the whole disclosure thing again.

Seb and Mae had similar experiences with being asked repeatedly about pregnancy, despite the fact that this was not possible given their sexual history. Mae shared that this assumption makes it difficult to have a productive medical encounter when the provider does not listen to and or believe what the patient has to say.

Seb shared that when they go to the hospital with their partner, who is also Black, "people tend to assume 'Oh this is like your family member, is that your sister or something?'" Seb explained "Just because we're two Black people here doesn't mean that we're related and I'm also not straight this is my partner."

Race as Biological

Participants spoke of racialized assumptions, particularly the false biological differences that Black people are believed to have in health and medicine. These were often related to weight and pain tolerance. Elle spoke of this in terms of false gendered ideals about body shape and size of Black people.

> If you're a Black woman and you are plus sized, it's because you're a Black woman, you know you're supposed to look like that. Or if you are a Black man, if you're more muscular, it's like, well, that's because you're genetically supposed to be muscular.

Although there are many outdated beliefs about Black people's health and abilities, these still present themselves today within various communities, including medical education and practice. Weight is one example of this, and Isaiah contributed their thoughts about language surrounding weight in Black communities.

> [T]here's a generalization that the downfalls of Black people are by choice not by either segregation, stigma, any just external factors that play into how we take care of ourselves. Any time I've ever talked about how it's more common to be overweight […] in the Black community […] it's like, "Ah yes, because you guys don't work." I hear that constantly. […] Society isn't built for us, and we definitely feel that.

Here Isaiah identifies the contribution of systemic and structural racism on weight discrepancies in Black populations while highlighting the racist assumptions of others who claim Black people are lazy without considering broader issues.

In addition to weight, pain was another factor that participants highlighted, explaining that it continues to be discussed in a racialized manner. Mae documented their experiences of their pain not being validated, or the perpetuation of “strong Black woman” discourse and stereotypes within medicine hearing comments like “Oh but you're so strong” from medical providers when they complained of pain. Mae felt as though these providers were “assuming that [they] can handle a certain level of pain more than somebody else who’s not a person of colour.”

Drug Use

Mae, Seb, and Elle experienced medical providers assuming they use or abuse drugs. Mae documented their experience of being refused of pain medication at the emergency department. They explained that medical providers have assumed they are coming to the hospital seeking pain meds because they are “abusing substances.”

> I feel like it's been assumed lots of times [when they] ask me probing questions about drug use and then instantly say “Oh you must be experiencing pain because you use cannabis.” […] The whole assumption that I'm an addict and I'm abusing drugs.

Medical providers assumed Mae used cannabis and told them that their pain must be related to this while denying them pain medication. Elle also had experiences like being described as “drug seeking” when attempting to access care related to her neurodivergence. Both participants noted the toll this took on the quality of care that they were able to receive when facing these incorrect assumptions.

Sex Work

One participant highlighted their experience having multiple medical providers assume she was involved in sex work. Elle shared that medical providers have asked her questions along the lines of, “Are you sure you're not more sexually active than you say you are?” and “What is your actual occupation?” Of course, participation in sex work could be relevant to one’s sexual health and thus relevant to their medical care, however, this line of questioning did not elicit trust and open communication.

Elle shared that twice she has been propositioned by physicians while attempting to seek medical care.

> Yeah, I’ve had two doctors actually proposition me, because as a trans woman, I must also be a sex worker. […] I was propositioned by two doctors [who basically said] “Would you consider ever going on a date” […]and things like that. I reported both doctors […] but nothing came of it because they're cis old white men that have been in the field forever. And it's my word against theirs.

Despite reporting this behaviour, Elle said nothing was done about these interactions.

Paternalism

Participants recalled medical providers insisting they knew what was best for the patient while failing to hear the patient’s requests or validate their concerns. Elle made a point of the distinction between nurses and doctors and this sense of paternalism.

> [Doctors] are like, “Well, do you really need that” […] or “I’m the doctor, so therefore...” And […] I've not had problems with nurses. It's doctors. And the reason I've had problems I think with doctors is because they have some kind of air about them.

Mae shared how attitudes like these may lead doctors to invalidate patients even though they lack knowledge about certain health concerns or treatments.

> My experiences with cis white male doctors and just how invalidating they are or them just speaking out of a place where it's like okay so you just said that's a

> “women's issue” but then when I'm asking you for help, you're like “I don't know what to do but I know that you don't need this” and it's like how would you know?

Non-Affirming Language

When asked to describe experiences of discriminatory or non-inclusive language in medical settings, participants spoke of being misgendered or deadnamed, discourses that pathologize or “other” them, and language that perpetuates the false ideals about being a “real” man or woman or being “fully” trans.

Misgendering or Deadnaming

Participants had experienced both misgendering and deadnaming which they indicated may signal a lack of awareness of TGD identities or a lack of respect.

Mae outlined an experience they had at the hospital where their gender identity was not respected by staff. After sharing their pronouns, Mae recalls a medical professional saying “I'm still going to call you ‘she/her’ that’s just how I see you. Don't take it personally that's just how I’m perceiving you so don't take it offensively.” Mae recalls that this provider continued to misgender them even after they asked the provider to please stop. Other participants shared similar experiences to Mae in emergency departments and walk-in clinics. When asked how this made them feel, Mae responded by saying they get “fed up” and often feel like it is not worth the struggle to continue to assert their identity.

Elle also recounted an experience where her deadname was repeatedly used at a pharmacy. Instead of apologizing, the pharmacist defended the staff member and Elle switched pharmacies. She also shared another experience from the emergency department where her bracelet listed both her deadname and her actual name. She questioned, “So I'm two people?” Elle felt confused and disrespected by this inconsistency.

Pathologizing, Other-ing, and Dehumanization

Elle explained her experience with pathologizing language, when she stated, "medical professionals act as though I need to be fixed, not treated." She continued to explain that medical professionals focus too much attention on gender dysphoria, and not enough time on positive aspects of gender diverse identities. Several participants echoed that the focus on psychological discomfort and distress is seen and felt by TGD people when accessing medical care. This idea that once TGD people are "fixed" they "get to the euphoric side of things" is not reflected by the lived experiences of participants.

Mae explained that interactions with medical providers have made them feel "crazy" for the way they identify and how they would like to be seen.

> I just feel like I've kind of been made to feel like I'm delusional or I'm just making up how I identify which doesn't feel super cool especially given the history of transness being seen and people still fighting to have it seen as a mental health issue which it isn't. [A] lot of language made me feel that way, like I'm just losing my mind or something.

Discourse employed by medical providers has made patients like Elle and Mae feel like something is wrong with them.

In a similar vein, language used by medical providers can also work to "other" or further marginalize certain groups. Both Elle and Seb spoke about the category "other" being used in medical paperwork, particularly when filling out intake forms. They described that they felt "disregarded," and that cisgender and binary identities were seen as more "dominant" when there was not a category available to encapsulate diverse gender identities.

When discussing pathologizating or other-ing language, Elle brought up an experience where a physician used language that dehumanized her. While in a postoperative unit of a hospital, she heard a physician ask his resident "Can you deal with *it*? I have more, better and pressing things to deal with." When asked how this comment, and others like it, impacted her quality of care, Elle responded by saying there is "no quality of care."

> I think it did more harm to me than anything because it also makes me not wanna trust medical professionals. […] It made me doubt myself. […] I think it hindered me and I think it made me not transition the way I wanted to, […] it definitely slowed me down because I was like, I don't wanna deal with all of this. […] Like there's been times where I've left different medical professionals and I definitely am worse coming out [when they are] not using proper terminology or proper pronouns, deadnaming, all the kind of stuff.

This example demonstrates the impact behind the words that medical providers use. Elle felt like she was not able to transition as quickly as she wanted to, or in the way she wanted to, because of experiences like this that made her doubt herself and doubt the medical system's ability to provide the care she needed.

"Fully" trans or "real"

Participants recalled experiences where medical providers perpetuated the idea of being a "real" man or woman or were told there is a way to "fully transition."

Isaiah commented on a different use of the term "real." They shared that some medical providers do not see TGD identity as being "real," and how providers may claim that TGD identities do not exist.

> [T]he countless amount of times I've heard that friends' doctors tell them that their identity doesn't exist is countless. To the point where like I wouldn't come out to my doctor because the conversation of her being like that doesn't exist is just not a headache that I want as a possibility.

Hearing these stories from other TGD friends has largely contributed to why Isaiah has not come out to their primary care provider.

Elle shared that TGD people often asked if they are a “real” man or woman. Elle explained that when medical providers use the word “real” it is hurtful, and that using a word like “biological” would be more accurate and appropriate. Mae faced similar language that perpetuates the idea that there is a way to “fully transition.”

Affirming Language

Participants were prompted in the interviews to share any medical experiences they would describe as positive or affirming, drawing on the specific language or communication used by medical providers that influenced the interaction. Participants spoke of how comfortable they felt with providers who used inclusive and respectful language and communication styles. Participants appreciated when medical providers acknowledged the limitations of their knowledge and experience.

Elle shared her positive experience with her current family doctor. Elle was very satisfied with the care she has received from her family doctor. She stated her doctor is affirming, asks questions in a respectful manner, and has worked to develop an open rapport with Elle. She also went out of her way to continuously ensure she would be prepared to help Elle with her aftercare following surgery. When Elle went for gender-affirming surgery, the surgeons explained how much effort her doctor had made to ensure she had enough information to provide sufficient aftercare for Elle. Elle also described that her doctor uses “proper language.” When I asked what she meant by this, she responded with the following:

> Pronouns, names, technical names for things so like AMAB and AFAB. […]. She's like, “I don't like saying that you used to be a boy. What is the technical term?” […] I told her about what AMAB and AFAB stands for. […] And if she doesn't know something, she has no hesitation of asking me because we have that relationship that she can ask me anything. She has no problem with it.

When asked how her doctor’s transparency and respectful communication makes Elle feel, she answered by stating that she can talk to her doctor about “anything” knowing that her doctor has Elle’s “best interest in mind.” Having this confidence in her care makes it “so much easier” than other medical interactions that Elle has had with providers that use disrespectful, non-inclusive, and judgemental language.

Isaiah also spoke about the comfort that comes from transparency and consent, explaining a time recently when they had a physical examination.

> I went to medical clinic because I had a penis infection and they asked me if they could touch me and when they were touching me, they were asking how I was feeling during the process. And having continuous check-ins when they were touching in the area was awesome.

Verbal consent and continuously checking-in with patients helped establish a respectful and positive encounter, especially when examining areas that were more private. Isaiah pointed out that this made them feel “very comfortable” and prevented them from getting “closed off.”

Seb also commented on the positive aspects of a medical provider with whom they felt comfortable when discussing their experience with a physician in Truro.

> I just never felt judged by her she was always very open and wanted to hear my opinion on things versus just saying all the doctory things and like expecting someone to follow. Yeah, that was really good experience.

This provider listened to Seb's opinions and thoughts instead of creating a one-sided conversation. The provider also used less formal language to help connect with Seb and reduce power imbalances. Participants appreciated when providers were transparent, used respectful language, prioritised consent, and did not communicate judgement. This helped them feel more comfortable and have more affirming experiences with medical providers.

Provider Identity & Communication Style

A medical provider's identity can have a large impact on the communication they are able to have with patients, and largely influences overall medical interactions.

Provider Identity

Participants in this study described the benefits of finding kinship with providers of colour, particularly noting the positive outcomes of having access to Black providers, and, similarly, having positive experiences with TGD providers.

When discussing providers of colour, and in particular Black providers, participants who had accessed a Black provider noted that their experiences were more comfortable than with other providers. Seb explained by stating:

> [I]t makes me more comfortable well and then I feel like I am even more honest with providers of colour just because I feel just inherently that there would be less judgment […] I just feel immediately more comfortable even if it's not a Black

> person just with another person of colour. I feel a sort of kinship there versus with white doctors.

Mae echoed this sentiment when spoke of their comfort when working with a trans social worker to prepare their top surgery readiness letter.

> [T]hey were really able to like use really gender affirming language […] So [they] made me feel really seen and validated those feelings and just taking my actual words and what I was saying and using that for my readiness letter.

Feeling seen, validated, and listened to resulted in a positive and affirming interaction between Mae and their social worker.

Not all participants have had access to Black, TGD, or Black TGD providers. All participants commented on how having access to a Black doctor would or had improved the care they received, while also acknowledging the lack of Black doctors, particularly in Nova Scotia. Isaiah, who has only ever had white cisgender women doctors, explained how they believed having "a Black provider or a male provider would definitely increase [their] comfortability." They explained that when they had a penile infection having "a man doctor would just like take away the pressure […] it would just be nice to not have that level of concern." Many participants noted the real or perceived benefit of shared identities in helping them relate and feel comfortable with medical providers.

Elle conveyed the challenge of finding a provider with concordant identity(ies), especially in Nova Scotia. She explained that she has never seen a Black doctor because of the shortages within the province and outlined the challenge of finding a provider who is a person of colour and queer.

Participants also spoke about having a bias against providers of certain identities, namely the traditional physician throughout history, the white cis male doctor. Elle described this as being a "knee jerk reaction" to the lasting effects of colonization. Elle further described this by explaining that both parties take part in this type of appraisal. "Within the medical profession they judge us by our appearance, you know, but subsequently so do we." Mae also acknowledged this "knee jerk reaction" as a "bias" they have developed from negative and invalidating interactions with "cis white male doctors." They stated that they "don't feel an energy of trust" and have difficulty opening up to cis white male doctors. They also explained that they often bring a white friend to accompany them to medical appointments. The racial concordance between their white friends and white medical staff have led to better health outcomes for them in the past, like more validation of their pain and quicker access to necessary pain medications. This is a strategy Mae learned to employ through their experiences in emergency care settings.

Communication Style

Beyond the specific words or language a provider uses, other aspects of communication style came up in interviews with participants. Codeswitching, or changing communication styles to match the interaction, was discussed by participants, which was closely related to provider identity. Listening was also mentioned and was noted as important marker of respect within medical encounters, influencing the comfort participants had with their medical provider.

Isaiah has not had access to a Black medical provider, but if they did, they feel communication would be easier because, for example, "I could use phrases that feel more normal to my language […] like slang." This idea of speaking comfortably with a Black provider and being able to use slang or other ways of speaking they would use with friends contrasts the way that they speak to their white doctor. Isaiah went on to explain this idea of codeswitching, which other participants also described, that they employ when speaking with their white cis female physician.

> [H]ow I engage with [her] is very, I would say cautious in a way. Being born a man, I already feel a barrier with women and like discussing how I'm feeling, I shift it in a way that basically isn't how I would speak to someone. Like using more educated language to better describe how I'm feeling from like her perspective. So, I would just say I'm not myself when I'm communicating with her.

Isaiah felt the need to think carefully about how to speak so their doctor can understand Isaiah's feelings. This awareness of their doctor's perspective was echoed by other participants.

Mae and Seb also noted the concept of codeswitching from the providers perspective. Mae pointed out that Black providers, or any providers of identities that have been marginalized, may have to codeswitch when they work within White-dominated systems and institutions.

> I think that there's probably […] regulations that make giving certain care harder to do […] which I also want to recognize that […] as a person of colour when you get into a space or you start working somewhere where a majority of folks are white that you have to be careful about how you conduct yourself in your practice or in your place of work because we're watched more closely.

Seb experienced this firsthand when they told their Black family doctor about a negative experience they had at the emergency department. Seb felt that their doctor might have wanted to do more but felt that maybe the system had “boxed her in” and that “there was more she wanted to say but maybe couldn't say or feared saying.” In the end, Seb said this contributed to why they “don't trust the health care system here at all basically.” Seb was acutely aware that their provider may not be able to perform the way she might like or may come off as dismissive because she is constrained by the system she works within. Seb acknowledged the impact of this communication style on trust.

Participants also shared their experiences of not being listened to during medical encounters. Whether medical providers believed they knew better than the patient, lacked respect, or were simply rushing through patients, participants did not feel heard or validated by these experiences with medical providers.

When I asked Mae if they felt as though providers listened to them when seeking care for what they suspected was polycystic ovarian syndrome (PCOS), they responded, “not really, no.” They continued to share:

> I've had doctors who have prescribed me things that if I had if I do have PCOS, […] could have caused serious damage to my health [and] could even be fatal. It was just like a birth control, but it had the wrong hormone in it.

Mae felt as though physicians have not listened to their symptoms, their history of ovarian cysts, and their family history of PCOS when evaluating diagnoses or prescribing medications.

Elle spoke about one reason that providers may listen less. She explained how the rushed nature of many clinics contributes to the lack of genuine listening.

> When it comes to private settings or when it comes to clinics it's very much that they're getting paid by the government and they're getting paid by the patient. So

> therefore, they get you in and get you out and half the time they aren't even listening to you.

This excerpt shows that all patients may experience this rushed clinical environment, including Black TGD patients.

Elle spoke more generally of the importance of physicians listening to diverse backgrounds and experiences outside of the clinic to educate themselves and prepare themselves to treat diverse patient groups. She spoke of her own experiences leading equity and diversity training for medical professionals.

> It's one thing to have these classes. When I teach these [trainings], I always say "Let this be a jumping off point for you. Don't let this be the end for you." But I think sometimes people are just like, "OK, I went to that class, check, good, I'm good for that now." But if you didn't really learn anything or listen to anything, then that's not going to help you.

Medicine: Medical Terms, Medical Education, and Medical Training

This section focuses on medical terms, medical education, and medical training. Participants spoke about positive and negative experiences with various terms and the need to diversify understandings of different terminology through educational efforts and professional training.

Medical Terms

When prompted to discuss medical terms, participants mentioned body dysmorphia, gender identity disorder, and gender dysphoria and euphoria as well as the idea of the labels *women's health* and *men's health*. Participants explained that some medical discourse has worked to frame gender diversity as an issue or mental illness and this language continues to contribute to pathologizing TGD existence. However, participants also noted that some medical language can be strategically employed by TGD people to access care and receive resources.

Body Dysmorphia

Elle described her discomfort as a young child, and how she did not initially understand that this had to do with her gender identity and not her weight.

> I was like "Ohh I'm fat," which then spiraled me into becoming even bigger. […] So maybe if I was explained by [a] medical professional that body dysmorphia is something that they used to use as a term for trans people […] it might have sparked something.

Here, Elle explains that body dysmorphia was previously used as a term for people experiencing gender dysphoria, and if she had access to a provider who could have explained this earlier it would have helped her. Elle also shared that body dysmorphia was a "big thing" that she felt had been used as a scapegoat to deny gender affirming care. Providers would tell her, "Well, you just have body dysmorphia. Maybe if you're on the right medication you'll be able to change."

Mae explained their experiences with body dysmorphia as a dynamic entity as opposed to the static understanding many medical providers use.

> You know our feelings are not written in stone and our experiences are not written in stone. […] There are some days that I experience body dysmorphia but there are lots of days that I don't. […] I don't think it can all be seen so black and white like that.

Both Elle and Mae spoke of the overuse or incorrect use of body dysmorphia in medical settings, which leads some TGD people to emphasize their experiences of body dysmorphia and its related distress to access gender affirming care.

Gender Identity Disorder and Gender Dysphoria

Participants commented on the pathologizing nature of the term gender identity disorder and the strategic engagement with this term to seek care.

Elle said, “I think is kind of weird because it makes it sound like you don't know what you are.” Elle believes the word *disorder* indicates an issue or a lack of clarity surrounding one’s gender identity, which is not the case for many TGD people. Mae also explained the harms of categorizing gender diversity as a disorder in medical communities.

> [T]o like pathologize our existence it's very off […] I just think it's harmful. We need to be more careful about that. […] We're all different we all have different experiences, and they should all be seen as valid. It’s not harmful to somebody else.

Mae argued that diverse gender identities should not be pathologized by casting these as disorders and again urged medical professionals not to conflate all TGD people’s experiences.

Terminology however can be a double-edged sword, as Isaiah pointed out that terms like *disorder* are sometimes needed to access financial supports. Isaiah worried that shifting terms without shifting requirements for assistance or accessing care could be problematic.

Participants also described their personal experiences of gender dysphoria and euphoria, and the use of these terms in medicine. Elle explained her understanding of gender dysphoria:

> I teach about dysphoria being a sweater you get for Christmas from your grandmother. It's itchy as hell, it's tight, it's got a tag in it, but you have to wear cause your grandmother is coming over.

She explained gender euphoria as "the complete opposite."

> Now, that sweater is loosened because you've washed it so many times because you've had to wear it so many times the tag is gone. It's actually softer now and also your grandmother isn't with you so now it's your favorite sweater.

She teaches this to students studying medical professions at Dalhousie. She also shared that medical professionals "focus so much on that itchy sweater that they don't focus on the softness that can be." Learning about this language from someone with lived experience is valuable for students to understand these terms and their use.

Seb discussed their dysphoria and euphoria and feeling less valid in their experience of these concepts.

> In terms of dysphoria and euphoria I feel like I can definitely relate to both. I do feel like sometimes as a non-binary person I feel like my dysphoria or euphoria is not as valid as someone that's like a trans man or a trans woman kind of like within that own non-binary category can feel a little bit pushed to the side, but I do identify with those terms.

"Women's Health" and "Men's Health"

Oftentimes within medicine, very gendered language is used to describe health concerns that typically correspond with a specific sex. Due to the existence of intersex people and TGD populations, this language is not correct, useful, or affirming. Mae and Elle explained their challenges accessing care and feeling affirmed when dealing with sex-related health concerns, diagnostic screening, and health movements.

Mae explained that medical providers often "use very gendered language. Just a lot of male doctors being like 'this is a women's issue.'" As a non-binary person seeking diagnosis and treatment for PCOS, Mae was not affirmed by the incorrect labelling of PCOS as a "women's issue" rather than as an issue for "people with ovaries."

Elle discussed gendered health language as well, when mentioning the risk of prostate cancer among trans women and the lack of inclusivity of many gendered health screening protocols.

> [P]eople don't know that trans women still have to have their prostate examined because we don't have the same pelvic floor as a biological woman. […] I'm still very much in jeopardy of having prostate cancer just as any other AMAB person.

She continued to share about sex-related cancers and the lack of inclusivity in the discourse of related health movements when she described the breast cancer movement as being "very geared towards women" noting that "biological men get breast cancer" as well as TGD people.

Medical Education and Training

When discussing medical provider training, most participants spoke of this in the context of medical school and physician training.

Current Medical Education and Training

Medical education or training typically involves professional competencies that touch on important equity, diversity, inclusion, and accessibility (EDIA) topics for medical professionals to gain experience with.

Elle shared this analogy about medical education.

> [A] doctor gets taught about the heart, the stomach, and the lungs. […] If they only got taught the heart and the lungs and somebody came with stomach issues

> and they're like, “I didn't really get taught that in school. I don't know how to deal with that.” That's why I think it's so important to be taught [TGD health] in schools for all medical professionals.

She then connected this lack of diverse medical education and training back to the very oath that is meant to guide physicians throughout their training and practice, to “do no harm.” To not harm patients, medical providers need to be equipped with the necessary knowledge to treat Black TGD patients. She shared, “Well, if you're not properly educated and you have a client that walks in that’s like me, then […] you're already doing harm. You're already disavowing your oath that you took.”

Some participants brought up the screening and application processes for medical programs, and how these may be able to ensure that those entering the medical field have these necessary skills and are open minded to the needs of others. Isaiah mentioned that these screening processes must attempt to grasp how providers communicate with diverse populations and how much they care about vulnerable groups.

While discussing the application process, Seb mentioned the challenges and barriers to entering the medical profession for people from diverse backgrounds which leads to less Black and TGD people that are doctors because it is “not super accessible.”

When it comes to the current state of medical education in Nova Scotia, all participants expressed their disappointment with Black health education. Isaiah shared that medical providers are “taught through a white lens, and they give that same advice and education through a white lens.” Isaiah gave an example of how this could impact their own care.

> I've had eczema my entire life and my doctor would recommend a skin treatment that may not work for Black people because how could she know that? […] So maybe like the cream that I used for being ashy doesn't mix well with the medication that she's prescribing. Or just like conflicts in a way that irritates my skin.

This is an example of how medical education is framed by and for white populations and how this continues to impact care for Black populations.

Improvements to Medical Training

Despite these challenges from the lack of diversity in medical education, participants had ideas to improve medical education and create more positive outcomes for diverse patients. A main point brought up in the interviews was engaging with diverse perspectives to create curriculum, teach lectures, and share lived experiences.

Isaiah asserted that "to be more inclusive to the education, you need to have a person of colour creating the education." Elle echoed this point by saying medical professional training programs need to consider "who is in the room" when decisions about curriculum are being made.

Participants also spoke of the perceived impact hearing about lived experiences could have in shaping the way medical professionals engage with their patients. Isaiah explained this when they talked about the difference between reading something in a textbook and hearing a real-life example.

> I think when you're building your education, hearing real life experiences of how you're hurting people […] is very powerful to change that behavior. You could put in a textbook that saying "it" to colored people is gonna offend them. But

> reading that and then a coloured person being like "that made me very uncomfortable," is very different.

Elle discussed the impact of hearing lived experience as well when she spoke of the unnecessary emphasis on having a medical degree for some aspects of medical education. When it comes to professional competencies and EDIA topics within medicine, lived experience can be more powerful and impactful than having someone with a medical degree teaching these topics. Seb also shared this same sentiment, stating that the "right people" are needed to represent diverse experiences.

Mae and Elle had some general suggestions to improve practitioners' ability to provide quality care to Black TGD people, and other populations that have been marginalized. Mae shared that medical education should encourage learners to listen to people of diverse identities, read diverse and radical voices, and question biases and assumptions.

> Listen to trans people, listen to Black people, listen to your Indigenous people, listen people of color. Seek out radical texts and listen to people's experiences like in thesis' like this, try to do better. And try not to make assumptions based on your own bias or question your own bias.

Elle acknowledged that challenging and questioning biases can be a difficult and uncomfortable process, and she said that people need to give time to "sit in uncomfortability." Naturally, people do not like to be uncomfortable, but she explained "sometimes, if you're uncomfortable it means you're learning something."

Continuing Health Education

Elle explained the significance of continuing health education. She shared that physicians often claim they do not have time to learn about Black TGD health needs, and she compared this to the need for an esthetician or hairstylist to keep up to date with trends. She explained that hairstylists will lose clientele if they do not adapt their services to meet the current needs in the modern day. She connected this to medical providers because they will not have the ability or skills to treat Black TGD patients if they do not continue learning, evolving, and caring about diverse population’s health needs.

In situations where providers may lack the necessary education or tools to help patients, Isaiah recommends open dialogue with patients while of course respecting that it is not their job to fully educate medical providers on these topics.

> This is a very gray line, but I do think asking your patients for education from them is very helpful. But of course, it can't fully be the responsibility of their patients.

Patients may be able to share helpful information to initiate further education for their providers.

Summary

This chapter presented data collected from participant interviews. The sections addressed the central research question and sub-topics by focusing on language used in medical encounters and how this influenced medical care. The themes: *Barriers to Care, Assumptions and Non-affirming Language, Affirming Language, Provider Identity and Communication Style, Medicine: Medical Terms, Medical Education, and Medical Training* were explained in detail. These themes spoke to how language impacted comfort levels, quality of care, and trust for Black TGD patients.

Chapter 5: Discussion

This chapter summarizes the main findings while further delving into their theoretical significance and drawing on social constructionist and Black trans feminist (BTF) principles and relevant scholarship. Following these summaries and discussions, this chapter presents the strengths of this study and the proposed broader implications of the findings for the medical and research communities. Finally, this chapter outlines the study's limitations, makes recommendations for future research, and provides final conclusions.

Barriers to Care

Access barriers, denials of care and medical gatekeeping made it difficult for participants to receive quality medical care. In Nova Scotia there is a scarcity of primary care providers which has led to decreased access to care in all areas of the healthcare system. However, as participants noted, physical access is not the only factor that needs to be considered. Patients deserve to have access to quality care that is compassionate and judgement free. The findings of this study align with the literature within the USA which demonstrates Black TGD people’s experiences facing denials of care (Seelman et al., 2021). This project’s findings contribute to Canadian data about Black queer and TGD people’s medical experiences, and particularly add a racialized perspective to Atlantic Canadian research about TGD people and their health and medical care. Social constructionist and BTF theories reveal how language that denies and gatekeeps gender affirming care reproduces harmful ideologies and assumptions about TGD identities. There is no one way to feel or look TGD, the labels within the TGD umbrella are assigned meanings through popular discourse.

Participants spoke of physical access issues and gatekeeping of medical care which are both important considerations because both are linked to poor mental health outcomes, including increased suicide rates, among TGD people (Bosse et al., 2022). Using social constructionism allows us to position social encounters, like a medical experience, as sites of conflict where power imbalances are revealed and disputed through language (Burr, 1995). BTF also reveals how power acts on individuals to shape understandings and experiences. Thus, we can see how gatekeeping gender affirming care asserts a medical professional's power to either validate and affirm one's gender or invalidate and deny access to medical interventions. Medical providers may be able to improve interactions with diverse patients with more awareness about how these power imbalances may change depending on a patient's identities.

The gatekeeping of gender affirming care that participants spoke of aligns with literature that has acknowledged how the World Professional Association for Transgender Health (WPATH) has assigned medical professionals a 'gatekeeping role' by continuing to require letters of recommendation prior to accessing gender affirming medical interventions (Bosse et al., 2022, p. 6). This works in tandem with the scarcity of health care providers trained and willing to work with TGD people to contribute to lengthy wait times to access medical transition (Bosse et al., 2022). In general, gatekeeping of gender affirming care indicates that there is more work to be done to understand the diversity among TGD identities to provide care in an affirming manner.

In terms of denying more general health concerns, Mae and Seb mentioned experiences being denied pain medication in emergency health settings. Physicians tend to be cautious about prescribing pain medications in general due to the highly addictive nature of many pain killers not to mention the disproportionate rates of substance use disorders in communities that have been marginalized (Johnston, 2019). However, it is important to be cautious about what information is being used to discern whether a patient may be seeking pain medication due to addiction, as well as the communication or line of questioning used to determine whether a patient is an appropriate candidate for certain pain medications. Previous studies in North America have found that white physicians both under prescribe and overprescribe analgesic to Black patients (Hampton et al., 2010). Another study found that Black and Hispanic birth givers were less likely to be given pain medication despite reporting high pain levels during and after birth (Badreldin et al., 2019). This indicates racial bias and the need for well-developed best practices to ensure that Black patients are receiving pain medications when appropriate (Badreldin et al., 2019; Hampton et al., 2010). This is a complicated and multifaceted area of medical care and providers working in emergency departments especially should be trained in how to successfully communicate with patients when making evaluations and treatment plans surrounding pain medication.

When discussing disclosure, physical access issues like the current lack of family doctors in Nova Scotia came up again as an important factor. This lack of primary care access leads to a reliance on walk-in or emergency services as the only accessible entry point into the healthcare system for many people. This is a challenge for Black TGD people because this results in the need to see a new medical provider each time they seek medical care. Participants spoke of their reluctance to disclose or seek care from new providers due to worries about intersectional oppression and discrimination. It is important to examine topics like disclosure and experiences in different areas of the medical system within TGD communities of colour, as these intersecting oppressions factor into the decision of whether to disclose or seek care, or not.

Participants spoke of medical providers making evaluations about their gender based on their appearance. This reinforces false beliefs about gender identity and expression being visible entities and does not outwardly allow patients the opportunity to disclose their identity. BTF promotes the interrogation of the notion that Blackness and transness are legible entities tied to a specific appearance or bodily characteristics (Bey, 2022). Providers must be open to the diversity in appearances of people of different identities. Providers may be able to help set the tone of the interaction by introducing themselves and their pronouns so that patients feel comfortable and safe doing the same and are thus able to receive care that starts on the basis of mutual sharing, and respect. Power imbalances significant impact the communication within a medical encounter. If a provider makes an effort to influence this dynamic by being open and inviting the patient to do the same, it may help improve the patient's comfort.

Passing was brought up by one participant who noted the privilege some TGD people have in avoiding disclosure or TGD-related discrimination. It is important to consider that TGD people who cannot pass as cisgender may be subject to very different medical experiences than those who can. The idea of disclosure is based on the fact that some TGD people have the autonomy to share their identity. Not everyone has this choice. Those who cannot pass may be more reluctant to interact with medical professionals, knowing that their identity will be known and may not be respected. The type of medical care a patient is accessing may also lead to differences with disclosure, depending on different physical examinations or tests that may reveal biological sex markers. This may lead to differences in what type of care patients feel comfortable having.

I thought it was a strong indication of the impact of negative medical experiences when all participants stated that a past medical experience had made them reluctant to seek future medical care. This aligns with other Canadian studies that have revealed a reluctance to seek medical care in Black and other racialized LGBTQIA+ communities (Ghabrial, 2017; TransPulse, 2021). Avoiding medical care can naturally lead to poor health outcomes (Kattari et al., 2015). Thus, medical providers could benefit from understanding the power of negative medical experiences in shaping health-seeking behaviours. Listening to patients and diverse perspectives in general, creating a safe environment for patients to disclose, and further education about TGD identities and health needs may help improve access to quality medical care and decrease reluctances to seek care for Black TGD people.

Assumptions and Non-Affirming Language

Previous literature in Nova Scotia has identified assumptions and non-inclusive or disrespectful language use toward TGD patients (Vermeir et al., 2018). This study's findings highlight a racialized perspective by voicing the medical experiences of Black TGD people in Nova Scotia. Assumptions about Black TGD people based on their appearance or identities reflect broader societal issues that may not be sufficiently addressed and dismantled within medical education or medical institutions. Social constructionist perspectives can be used to unpack assumptions like this by urging individuals to question and critique assumptions tied to certain groups or identities (Burr, 1995). Similarly, BTF theories can be used to deconstruct hegemonic assumptions about race, sex, and gender while theorizing how power relates to these identities (Bey, 2022).

These paradigms and theories were used to examine assumptions participants felt their providers had made and highlight the underlying power structures present within medical interactions. While examining these experiences, it is important to consider that the meaning of certain experiences or discourse varies for different people. Medical providers may not be aware of subconscious bias or assumptions they hold. However, a patient’s lived experiences and community narratives are used to interpret the meaning of phrases or words used by their medical providers. More awareness of the sociohistorical realities that shape the way diverse patient populations communicate and how language may be perceived by different groups may help improve the language used by medical providers.

The main assumption that all participants spoke about was medical providers assuming their gender. BTF principles expose the coercive nature of the gender binary and reveal how these evaluations produce the identity options, or non-options, for Black TGD patients in medical settings (Bey, 2022). When gender is assumed to be cisgender or to exist within the binary, this shuts down the option for TGD people to disclose or exist as themselves within the space. Social ideals about gender norms shape the way gender is understood and assessed and create the acceptable gender options in various spaces including medicine. Another important factor to consider is that one’s experiences construct the way they see the world and the way they categorize other’s identities, according to social constructionist views (Burr, 1995). With exposure and awareness about gender diversity, there is hope that these compulsory categorizations may be adapted.

Assumptions about biological differences of Black people were also mentioned, particularly with respect to weight and pain. Health concerns are often credited as inherent to Black people through genetics or so-called lifestyle choices instead of recognizing the systems and structures that continue to stifle the ability of Black people to access health services and make healthy choices. As previously stated, racial bias has led to differences in the prescription of pain medications for Black patients (Badreldin et al., 2019; Hampton et al., 2010). In terms of denials of pain medication, there is a false notion that Black people have higher pain tolerances that originated during slavery and continues to be perpetuated in medical education and medical discourse (Dryden & Nnorom, 2021). Black people who are perceived as women may receive care guided by the stereotype of the "strong Black woman" which can result in the refusal of pain medication (Etowa et al., 2017, p. 379). Of course, pain medication may be denied for a number of reasons, however, these stereotypes and sociomedical discourses may lead providers to subconsciously deny care for these reasons or may lead Black patients to interpret denials as being related to this.

Participants also spoke of assumptions about their lifestyle including the insinuation that one participant was involved in sex work. These medical providers may have made this assumption based on popular understandings of sex worker's identities and the hyper-sexualization of Black and trans women within society (Snorton, 2017). Communicating this assumption to the patient in an accusatory manner and propositioning that patient is likely to exacerbate existing power imbalances within the medical encounter not to mention going against professional ethics. Engaging in sex work can impact one's health and may be relevant to their medical care, however, the intention behind this commentary did not seem to have the patient’s health and wellbeing in mind.

Participants also felt that medical providers sometimes guided their practice using principles of paternalism when they identified that physicians in particular may let their ego get in the way of their provision of care. The road to practicing medicine is long and difficult, however, once physicians reach the point of practicing medicine, it is important to strive for humility and ensure they are hearing patient’s concerns and ideas. There are definitely societal discourses that perpetuate the idea that physicians have a God complex or a certain “air about them” as one participant stated. These collective understandings may be rooted in real experiences, but it is also important to consider that these descriptions may contribute to patients having a confirmation bias about this behaviour. Assumptions go both ways in framing how a medical interaction is interpreted by both parties.

Participants also spoke about their providers using non-affirming language, like misgendering or deadnaming them in medical encounters. When a provider refuses to use the name and pronouns the patient identifies with it signals a lack of awareness and respect for diverse gender identities. It is critical to note the power that medical providers have in labelling someone a certain gender, or denying to refer to them as their gender, and how this power creates a dynamic that fails to serve the needs of TGD patients. The use of incorrect pronouns or someone’s deadname is a tool that can be used to exert power over patients and decrease trust and comfort within the medical encounter.

Medical discourse that is other-ing, pathologizing, and de-humanizing is often focused on within a historical context, however, as the participants shared Black TGD people today still encounter this kind of language. It is important for providers not to use words that imply further meaning, beliefs, or judgements about certain identities. Using social constructionism and BTF, language can be unpacked to see how societal norms have informed medical discourse and how these discourses continue to reproduce stereotypes in society (Bey, 2022; Burr, 1995). This study recognizes the power medical provider’s language has in conveying beliefs and shaping experiences for patients. Particularly, when one participant was referred to as “it” during a hospital trip, that physician was defining the patient as being non-human which signalled their own beliefs about and lack of respect toward Black TGD people. The use of this language does not affirm Black TGD people to feel validated and comfortable in their identity when seeking care and does not lead to positive and fulfilling medical interactions.

The last example of non-affirming language the participants mentioned was the idea of being a “real” man or woman or “fully” transitioning. The current gender categories and the meaning behind the labels “man” or “woman” are shaped by sociohistorical conditions which may limit the scope of their use or the way gender is categorized. However, social constructionists see the potential for the meaning behind language to change and the possibility for further categories, because discourses are not seen as being monolithic or static (Burr, 1995). Social constructionists note that “where there is power, there is also resistance” (Burr, 1995, p. 51). BTF also encourages resisting current power structures to reimagine definitions and categories that better serve those of identities that have been marginalized (Bey, 2022). Resistance by leaders in society can contribute to redefining gender categories and introducing new labels to better represent diverse gender identities. It is of particular importance that members of the medical community are part of this resistance because of historical and present use of medicine and biology to deny the existence and validity of TGD identities (Snorton, 2017). Additionally, the very concept of "fully" transitioning reinforces the ideal that an individual is not TGD unless they take part in various forms of medical transition. TGD identities are dynamic and unique to each person, thus there should not be a one-size-fits-all approach to transitioning or language that makes it seem as though transitioning is an all-or-nothing entity. Language that communicates assumptions or is disrespectful, non-inclusive, and not affirming should be called out, critiqued, and not tolerated within the medical system.

Affirming Language

Positive, affirming, and respectful encounters shared by participants may offer guidance for best practices while instilling hope for the potential of the medical field in affirming Black TGD people. Physicians may be able to learn from the language providers used that stuck out to patients, positively impacted medical encounters, and improved patient-provider relationships. Previous studies tend to focus on negative aspects of medical encounters, so these findings contribute positive experiences from Black TGD patients.

Participants spoke of how "proper language" practices, like using correct pronouns and technical names or terms like AMAB and AFAB were impactful, which shows that simple signals of respect and keeping up to date with best practices for language can help patients feel comfortable and may increase their ability to open up and trust their provider. Participants also mentioned the importance of consent to increase comfort within medical appointments. Particularly during physical examinations, it is helpful to explain each aspect of the exam and continue to check in with the patient to make sure they feel comfortable. Past experiences within and outside of medicine can contribute to discomfort with physical examinations. Being aware of this and prioritizing continual consent aligns with trauma-informed care approaches which may lead to more open communication and trusting relationships (Reeves, 2015).

When discussing comfort, participants spoke of the importance of transparency, listening, using less formal language, and refraining from communicating judgements. These practices may reduce power imbalances and engage patients by helping them understand and be involved in decision making regarding treatment plans. Any patient may feel a power imbalance with their medical provider, so understanding and prioritizing patient comfort may help medical providers connect with all patients and provide better care. Medical providers and medical educators may benefit from understanding the impact of this affirming language use on helping patients feel more comfortable and confident in the care they are receiving and may be able to implement and promote similar practices in their own provision of care.

Provider Identity & Communication Style

While discussing the impact of provider identity on medical interactions, it is important to note that one must assume the participants in this study were correctly deciphering their provider's identities. Due to the possibility of a provider passing as a different identity or being assumed to be a different identity, these interpretations may not always be accurate. Nevertheless, the perceived identities of medical providers had an impact on the participant's medical interactions.

Participants indicated the comfort and trust they felt with providers they perceived as having concordant identities, which aligns with the findings of previous studies conducted in the United States and brings a Canadian perspective (Howard et al., 2019;

Hudson, 2019). This can be understood using the social constructionist view that a person’s identity plays a large role in the language they use and their understandings of the meaning behind various labels or phrases (Burr, 1995; Guba & Lincoln, 1994). Social constructionist theorists view people and the language they use as bound to one another. The way language is structured is thought to determine the way that experiences and identities are structured and categorized (Burr, 1995). Naturally, the language one may use to describe an identity they have is likely to be rooted in lived experiences and may be more similar to others with shared identities. Those of identities that have been marginalized may reject the popular social or medical discourse of dominant groups and assumptions that may not serve or represent diverse populations which may contribute to the ease of communication between patients and providers of concordant identities.

Despite this, access to providers of colour, or TGD providers was slim, and participants described that they were aware of their own biases against physicians they perceived as white cis males. Participants even learned about different strategies to appeal to whiteness and tap into privilege to protect and benefit them in medical spaces. They also described the codeswitching they did in medical spaces. Receiving medical care can be stressful and emotional for a multitude of reasons in general, so having this extra strain of putting effort into communicating in a particular way further complicates this interaction. The pressure patients felt to communicate in this way suggests that they believe medical providers have expectations for their patients to speak in a certain way to obtain care. Black TGD people learn through their communities about certain ways of speaking to get faster and higher quality care. Participants spoke of the power imbalances that contribute to patients overthinking and feeling stress within medical encounters.

BTF highlights the notion that Black people sometimes experience their sense of being through other's perceptions which may contribute to the need to present in a certain way depending on the identities of the provider or the context of the medical encounter. This relates to the social constructionist argument that labels such as Black and white, TGD and cisgender, or even patient and provider, can serve to support power inequalities between individuals, while passing off this imbalance as fair or natural (Burr, 1995; Milner & Jumbe, 2020). This makes it seem as though inherently one of these groups deserves more respect. When Black people are associated with lower intelligence or seen as less articulate in society, it may contribute to Black patients thinking more about how they are going to communicate with a white provider to counteract these preconceived notions attached to this label, and the perceptions others have about Black people. It is societal understandings of what these labels mean that contributes to this power imbalance. Besides their personal codeswitching, participants were also acutely aware of medical providers of diverse backgrounds having to codeswitch within the constraints of medical systems and medical institutions which impacted their trust for said providers and systems. This may suggest that these systems need to be re-evaluated and reinvented so that medical providers are not held back from providing affirming medical care.

Participants also recalled a lack of listening from providers in past medical appointments. Bias is already noted at alarming rates in Black patient's electronic medical record notes, and providers have been found to offer less patient-centred care for Black patients, which may indicate that populations that have been marginalized like Black TGD people could be more vulnerable to not being listened to or taken seriously during medical appointments (Beach et al., 2010; Johnson et al., 2004; Sun et al., 2022).

Medicine: Medical Terms, Medical Education, and Medical Training

Participants mentioned the impact of medical terms used to describe their identities and health concerns while noting the potential for medical education to improve inclusive and affirming language practices. BTF theories facilitated a deeper examination of medical terms to recognize and name their limited or oppressive scope while imagining improvements to better serve Black TGD patients (Bey, 2022). BTF also urges the consideration of the history and origin of medical knowledge and medical terms which have emphasized biological sex as synonymous with gender and developed this into a norm (Bey, 2022; Stryker, 2017). Generally, participants noted that medical terms had limited definitions that could benefit from encompassing the diversity that exists among TGD identities and experiences. In some cases, aspects of the label itself were harmful, for example the use of the word *disorder* in gender identity disorder has a pathologizing nature, or the use of gendered health language when this is not accurate or affirming. However, in other cases it is not the label itself, for example, with body dysmorphia or gender dysphoria, but rather how these labels are taught to medical learners and how medical providers use these in practice that could use improvements.

For example, although TGD people may experience body dysmorphia, this term is often conflated with gender dysphoria, although the two are not synonymous (Bushell, 2023). Medical providers should understand the key differences between the two, with body dysmorphia being an anxiety disorder where individuals have a distorted view of themselves and shame about their body, and gender dysphoria being a disconnect between one’s gender identity and one’s sex assigned at birth (Bushell, 2023). The findings of this study also bring further perspectives to previous research that has examined the use of the terms gender identity disorder and gender dysphoria or euphoria

(Johnson, 2018). Participants acknowledged that within the current medical system, labels and diagnoses are often necessary to gain resources and access to gender affirming care. There are ways to make this less pathologizing and more affirming for TGD people to continue to access lifesaving gender affirming care, like the informed consent model previously discussed, however, this is not always the favoured approach in different regions and settings. Looking at gendered health language, there have been widespread shifts in recent years to improve the accuracy of medical language, like the shift from *pregnant women* to *pregnant people* and more inclusive language surrounding menstruation in medical communities. This shows promise for the future of many terms, however, there is still work to be done.

The findings of this study also bring a new perspective to previous studies that have examined medical education, and lack thereof, regarding Black health education and TGD health experiences (Dryden, 2022; Hassen et al., 2021; Sieroka, 2021). BTF is useful here to remain grounded in the fact that medical education was historically developed by and for white people and that whiteness and white scholarship continue to dominate medical spaces (Bey, 2022; Dryden, 2022). Fortunately, organizations like the Black Health Education Collaborative are currently working with the Medical Council of Canada to develop Black health learning objectives aimed at addressing anti-Black racism in medical practice and making this a part of qualifying exams for medical students. Medical institutions and providers have immense power in categorizing identities and related health concerns therefore having people with diverse backgrounds engaged in creating medical education and medical research may afford them the power to frame discourses and explain language practices that may better serve diverse patient populations which may help center power imbalances. This project's findings bring suggestions to improve education and admissions to create a more affirming and knowledgeable medical field for a variety of diverse populations.

Although the medical field has become increasingly diverse over the past few decades, the findings of this study align with other research that has demonstrated that there are still pressures to conform to a particular role within medicine that stifle the ability for drastic changes to be made within the medical system (Lorber & Moore, 2002; Rodríguez et al., 2022). Physicians of identities that have been marginalized often pay a "minority tax" which refers to the fact that they are more likely to participate in unpaid diversity efforts, be the targets of racism, experience isolation, not have access to genuine mentorship, have increased clinical responsibilities when compared to non-minority peers, and are considered for promotion less than their peers (Rodríguez et al., 2022, p. 5). This leads to a lack of diversity among people in power in academic medicine and clinical settings (Rodríguez et al., 2022). Thus, diversity in the medical field may not yield as effective results as having increased diversity among people in power to reimagine how institutions operate and teach.

Recommendations

1. **Medical communities must recognize the diversity among TGD identities.** Conversations around the gatekeeping of medical care highlight the need for medical professionals to understand and accept the diversity of gender identity and expression. Medical professionals should recognize that TGD identities are not monolithic thus should not provide a one-size-fits-all approach to care. Medical education and medical terms should similarly reflect this understanding.

2. **Primary care reform should consider vulnerable populations like Black TGD people.** There has been growing commentary on primary care reform, particularly improving payment models to reflect patient and provider needs and allow more time for appointments (Watson, 2023). Populations like Black TGD people should be accounted for in future decisions to increase time spent with patients because this may contribute to increased listening and make patients feel more heard. Nova Scotia has announced that there will be a shift in their primary care waitlist to a needs-based model with priority designation given to those with chronic health conditions (Glass, 2023). Nova Scotia should also consider prioritizing populations facing marginalization due to intersecting social determinants of health and challenges accessing emergency and walk-in services, like Black TGD people.
3. **Patients should be further engaged and empowered in medical settings through shared decision making.** Physicians and health scholars have recognized the advantages of patients being included and further engaged in medical decision making and treatment plans (Kennedy, 2003). Some physicians even encourage the idea that patients should be consulted as experts in their own identities and personal health needs (Kennedy, 2003). Medical providers have recognized that to properly care for a patient and address their needs both the patient and provider need to acknowledge and respect each other's area of expertise. As such, patients should be engaged and empowered when making decisions regarding their care (Kennedy, 2003).

4. **The informed consent model should continue to be promoted, evaluated, and updated to best serve patient needs.** The informed consent model for gender affirming care has become more commonplace throughout Canada, including in Nova Scotia, which respects a TGD person's right to self-determination and does not rely on a diagnosis of gender dysphoria to prescribe hormone therapy (PrideHealth, n.d.). This model should continue to adapt as more is learned about TGD population’s needs.
5. **Medical providers should learn and use inclusive language in intake forms and clinical practice.** Medical providers should exert caution when asking about a patient’s sex assigned at birth, when relevant, and ensure more accurate terms like biological, AMAB, AFAB are used instead of questioning if the patient is a “real” woman, for example. Clinics should also ensure sex/gender categories used in paperwork are inclusive to diverse gender identities. This can signal that the clinic or hospital has thought about the needs of TGD people and can set the tone for the medical encounter. This can help patients feel more comfortable disclosing their TGD identities and may lead to a more open, genuine, and comfortable interaction for both parties.
6. **Medical professional training programs should evaluate compassion and biases throughout the admissions process.** Participants spoke of how the application and interview process for medical professional programs should attempt to grasp or measure how much a person genuinely cares about others, especially those of different identities. Many medical professional programs already employ tools that can reveal applicants’ personalities, biases, and

communication skills and these should continue to be promoted while evaluating the efficacy of these measures.

7. **Medical professional training programs should continue to increase diversity among learners.** Participants suggested that medical education could be improved by having more diverse learners, who can bring their lived experience to enrich medical education for all students, and of course result in a more diverse medical field. Having diverse students in the classroom enriches group discussions and highlights different perspectives to improve learning for all. Many admissions pathways, like the Black Learners Admissions Pathway beginning at Dalhousie in the 2024 admission cycle, have been established at medical schools across the country (Rogers, 2023). Other resources and supports should be provided to youth of diverse backgrounds and prospective applicants.
8. **Strategies must be employed to increase diversity among positions of power in medical institutions.** There should be more opportunities and strategies to recruit diverse candidates for leadership roles in medical institutions. Without diversity in positions of power, systemic changes are less likely to occur.
9. **EDIA training should be continuously promoted and utilized by medical professionals.** Medical providers could benefit from an awareness of their own personal biases and assumptions as well as the hesitance patients may have with providers of different identities. Considering that diversity among medical providers is not going to change drastically overnight, efforts can be focused on education and training that promotes equity. Complex areas of care, like pain management, should be taught with EDIA concerns in mind. It is crucial to

understand that medical providers of any identity can bring respect and inclusive language to a medical encounter and work to rebuild trust in the medical system.

Study Strengths, Significance, and Implications

This section will outline the strengths, significance, and implications of this study and its findings. Participants in this study shared their medical experiences, with careful attention to language they recalled their medical providers using. This is significant because this is an under-researched area; this may be the first research work that has solely focused on the experiences of Black TGD people within Nova Scotia. This may inspire future research with this population or initiate important conversations in medical research and practice.

The implications of this study also have personal significance to me as a researcher. This study allowed me to strengthen my qualitative research abilities while partially fulfilling the Master of Arts in Health Promotion program at Dalhousie University. This study also advances my knowledge about medical experiences for Black TGD people in Nova Scotia which is of great relevance to me in my work as a research assistant for the James R. Johnston Chair in Black Canadian Studies and the Black Studies Research Institute in Dalhousie University's Faculty of Medicine. Additionally, as an incoming medical student, my goal is to become a medical provider that can be a strong ally and advocate, continuing to amplify the voices of Black TGD people, serving their needs and listening as these adapt. Through this project, particularly in the recruitment phase, I was able to make many new connections within the non-profit and health field, and advance connections I had already established, which will benefit me in my future professional career. In addition to academic and professional advantages, this research allowed me to continue to educate myself, and others about the experiences of

Black TGD people, and how these can be improved, which has been and continues to be a rewarding experience.

This research may also have significant implications for Health Promotion as a field. This study adds to existing TGD health promotion literature in Nova Scotia by qualitatively studying the impact of language use on Black TGD people's medical experiences. This contributes further examination into the intersectional experiences of TGD people with more than one identity that has been marginalized. This study also adds to existing health promotion literature in Nova Scotia that has focused on Black communities' medical experiences. The findings of this study could advance health promotion research in this area by examining more factors that influence Black TGD medical experiences and overall health.

Health promotion examines health outcomes by looking beyond individual health behaviours to social and political factors (Heard et al., 2020). This research aligns with this lens by examining how societal, systemic, and institutional forces, create dominant discourses that influence the medical experiences and medical opportunities for Black TGD people. These findings could be considered in the development of new initiatives to improve the language used by medical providers and promote respect and listening to Black TGD populations, as well as other diverse patient populations. Such initiatives may implement or re-imagine current medical education and training efforts. Understanding the discourses in use can help craft effective messaging, particularly in educational and research contexts. The findings of this research could be used as a rationale to explore the impact medical language has on other patient populations. This work may inspire future research in health promotion to consider groups facing intersecting oppression, like Black TGD people, and to consider how language influences medical encounters.

Knowledge Translation

While recruiting for this project, many community organizations and clinics were interested in the findings of this study. Although Black TGD people are one of the most marginalized populations in society, Canadian data is lacking for these populations, particularly in Atlantic Canada. It is important to share the key results from this project in an accessible format for community organization staff, and staff at medical clinics to be able to gain an understanding of Black TGD medical experiences and the language that has greatly influenced these encounters. For this reason, I crafted short infographics with the main findings to clearly display the themes and lessons learned from this project (Appendix E). This may help medical providers better understand the impact of their language as well as language best practices for patients. This may also help community organizations with their language practices or help them support patients who may be navigating the medical system.

In terms of medical education efforts, the findings of this study may also be significant for medical schools, nursing schools, and other medical professional training programs. The findings could be used in the creation of educational tools or curriculum to teach students about intersectionality, the experiences of Black TGD people, and language best practices when treating diverse patient populations. I hope to incorporate these findings in medical school lectures at Dalhousie. One aspect of my role as a research assistant for the James R. Johnston Chair in Black Canadian Studies in Dalhousie University's Faculty of Medicine is to help the Chair create lectures for medical students focused on Black queer and trans health. These lectures are given to second year medical students at Dalhousie as part of their professional competency curriculum. I plan to share the findings of this study within these lectures, to give a local example of medical experiences in the HRM, while also ensuring the impact of this language on these patients encounters and lives is adequately conveyed. The findings could also be used for continuing medical education, and blogs or other platforms that share knowledge in medical communities.

Finally, I hope to work on a version of this thesis to be published in a relevant academic journal. This will require condensing the thesis based on the most relevant information and reconfiguring the format to align with a prospective journal's guidelines. I hope by doing this I will be able to reach a wider audience of medical professionals, medical educators, and medical researchers, to share insight into the current state of language use, the impact of language, and language best practices to improve communication and overall interactions with patients.

Limitations

Acknowledging the limitations of a study is critical to guide how the findings may be interpreted and used. The limitations of the present study have been carefully considered and are discussed below.

The most important limitation is that this study's sample is not representative of the entire Black TGD population in Nova Scotia. Finding a representative sample was not the intention of this project, nevertheless, there are still important considerations to discuss about the individuals who were willing and able participate in this study. Of course, only those comfortable discussing their identities and experiences volunteered to participate, which presents a limitation because the voices of those who may not be "out" or otherwise uncomfortable discussing medical experiences could not be included.

Additionally, those who do not have access to medical care, avoid medical care, or simply have not recently accessed medical care were not eligible to participate. Recruitment for this study was mainly done through community-based organizations that work with Black TGD people, thus the voices of individuals who may not be connected with these supports, resources, and organizations were not included. Additionally, three out of the four participants had a family doctor, which contrasts the fact that many Nova Scotian's are without access to primary care (Glass, 2023). This tends to be an issue that further impacts people of identities that have been marginalized, making this an important consideration when interpreting the findings. It is critical to consider the goal of this project, which was not to obtain a representative sample of participants to produce generalizable findings. Instead, this project aims to further understand the medical experiences of Black TGD people in Nova Scotia while contributing the first piece of research within these populations in this region.

When providing context from the results of this study, it is important to consider geographic region. It is possible, and likely, that the medical experiences of Black TGD adults in Nova Scotia may may differ from Black TGD adults' medical experiences elsewhere. It is also probable that people in different geographical locations within Nova Scotia might have distinct experiences with medical care. The purpose of this study was to explore Black TGD adults in Nova Scotia. It is important to consider that the participants in this study all currently lived in urban settings, in the HRM, therefore the findings do not speak to the experiences of Black TGD people in rural Nova Scotia, or elsewhere.

This project focused on the medical experiences of Black TGD people, honouring, listening, and respecting their perspectives. With this said, this study only examined the perspective of Black TGD people and not their medical providers, offering only one side of the medical interaction. Therefore, without the providers perspective, this study is limited to the patient's perspective. However, qualitative research views individuals as experts of their own experiences validating the truth behind the experiences shared in this study (LeVasseur, 2003). This study is also guided by the principle of patient-oriented research, which view patients as experts in their own health and well-being (Allemang et al., 2022). With that said, it is important to consider that every encounter has more than one side. Future projects may offer medical providers an opportunity to share their perspectives on the care of Black TGD patients.

Recommendations for Future Research

This study had a small sample, and it is important to bear in mind that Black TGD identities and experiences are not a monolith. This came up throughout the interviews, is stated in the findings, and will be reiterated here when I state that further studies are required to learn more about Black TGD experiences and how to best support Black TGD people to improve health and wellbeing. Future work could employ quantitative methods to gain a deeper understanding of racialized TGD communities and their medical experiences across Canada. Studies could assess current medical education by reviewing medical professional training program's curricular content, or lack thereof, regarding intersectionality, Black health, gender diverse health, and Black TGD health. Future research could also focus on the provider's perspective, assessing the comfortability of providers with treating Black TGD patients, examining the education and training they have received, extra reading or work they have done to equip themselves, or their perspectives on experiences with diverse patient populations.

Conclusion

Within Nova Scotia, the medical experiences of Black TGD people had not been accounted for in previous research, nor had research solely focused on examining the impact of medical language and communication on patient-provider encounters. This project contributes to a significant gap in the existing literature related to TGD people which had predominantly white participants and focused more broadly on a variety of factors that impacted medical experiences. This research examined language used by providers and how this impacted medical encounters, as recounted by four Black TGD participants. A social constructionist and Black trans feminist approach was used to analyze five main themes; *Barriers to Care, Assumptions and Non-Affirming Language, Affirming Language*, *Provider Identity & Communication Style, and Medicine: Medical Terms, Medical Education, and Medical Training.* Within these themes are excerpts from participants, who shared examples of affirming and non-affirming language, how this language affected their medical encounter(s), factors that influenced language, and ideas to improve language used by medical providers. The language used by medical providers was theorized as being reflective of sociocultural norms, beliefs, and ideologies. This provided insight into the complexities of societal and medical beliefs about Black TGD identities, health needs, and rights. The findings revealed that medical providers often communicated assumptions about the participants or used non-affirming language when describing TGD identities or health needs. Participants recalled being denied care or having care withheld from them unless they fit within cisnormative ideals. Experiencing this non-inclusive language made participants frustrated and disappointed while greatly compromising the care they received. Participants greatly appreciated when medical providers used respectful and inclusive language, like neutral or correct pronouns, and were transparent about knowledge gaps while actively seeking out further education. Participants suggested that involving diverse decision-makers and educators to teach about communication and language might be more impactful for medical education and training reform. This research provides an opportunity to listen to Black TGD people's experiences with medical care and work to understand how language used within medicine reflects sociohistorical and sociopolitical ideals that do not validate the existence or serve the needs of Black TGD people. The main goal of this project was to amplify the voices of Black TGD people and provide medical providers, and the broader health research community, with information about the lasting impact of words on Black TGD medical experiences and wellbeing.

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Appendix A. Interview Guide

1. How is your identity (racial and gender) usually disclosed or discussed in medical appointments? (e.g. not disclosed, disclosed on intake papers, disclosed through conversation, provider asks directly, assumptions, etc.)
    a. How do you feel about the disclosure process/how your provider initially assesses or discusses your identity?
2. Have you ever felt reluctant to disclose your gender identity in a medical setting?
    a. Are you comfortable explaining the main contributing factor(s) leading to this reluctance?
3. Can you recall a time when you have felt comfortable or affirmed by the language used by a healthcare provider?
    a. Can you describe this experience?
    b. How did this impact the quality of medical care you received?
4. Have you ever experienced non-inclusive or discriminatory language in a medical setting (i.e. examples of cisnormativity, misgendering, reinforcements of gender binary, whiteness as a baseline/norm)?
    a. Are you comfortable sharing this experience?
    b. How did this impact the quality of medical care you received?
5. Has a healthcare provider ever communicated assumptions about your lifestyle or health based on your gender identity, race, both?
    a. Are you comfortable sharing an example?
    b. How did this impact the quality of medical care you received?
6. Have you ever felt like your identity (racial, gender, or both) has been pathologized by a medical professional?
    a. Are you comfortable explaining this?
    b. How did this impact the quality of medical care you received?
7. Has a previous medical experience ever made you reluctant to seek medical care?
    a. Are you comfortable sharing that experience?
8. Do you feel represented by the medical terms "gender identity disorder" or "gender dysphoria"?
    a. Why or why not?
9. How does a provider's identity (racial or gender) impact the communication you have with the provider?
10. Do you feel as though medical providers in Nova Scotia have adequate knowledge about trans and gender diverse health?
    a. Why or why not?
    b. Has this ever been reflected in the way a provider has communicated with you?
11. Do you feel as though medical providers in Nova Scotia have adequate knowledge about Black health?
    a. Why or why not?
    b. Has this ever been reflected in the way a provider has communicated with you?
12. Do you feel as though medical providers in Nova Scotia have adequate knowledge about Black trans or gender diverse people's health, or the health of other dual or multiple minority groups?

    a. Why or why not?
    b. Has this ever been reflected in the way a provider has communicated with you?

13. What do you think would be the most effective method to improve respect and inclusivity in the language used by medical providers?
14. Is there anything else you would like to share?

Appendix B: Email Invitation

Hello _______,

My name is Maya Lowe, and I am currently working on a Master of Arts in Health Promotion at Dalhousie. I have chosen to explore the medical experiences of Black transgender and gender diverse Nova Scotians for my thesis project.

I want to thank you for your potential interest in participating in my project and tell you a bit about the project and what your participation would entail.

To be eligible for participation, you must be:

- Over 18 years of age
- Speak English
- Identify as Black/African Nova Scotian/have African descent AND identify as transgender or gender diverse (non-binary, gender queer, etc.)
- Live in Nova Scotia
- Have had a medical appointment in Nova Scotia in the past 5 years.

My project focuses on language used by medical providers, specifically how the use of certain language impacts comfort and quality of care for Black transgender or gender diverse people. If you are open to discussing your experiences with medical care in Nova Scotia, you would be invited to schedule a 45-minute interview with me either in a private room on Dalhousie campus or over Microsoft Teams. You would be compensated with a $50 visa gift card, and would be reimbursed for any travel expenses (parking, gas, taxi, or public transit) up to $25. Your participation in this study would only be known to the research team, and all information you provide would be confidential.

If you are interested in participating, I will send a screening survey to determine your eligibility. I will also send you a consent form that will outline more details about my study and your participation. We can then schedule the interview. You would be able to withdraw your participation from the study at any time before, during, or up to one month after your interview.

Please reach out if you have any questions or concerns. I look forward to hearing from you.

All the best,
Maya Brady Lowe
she/her/hers
maya.lowe@dal.ca
(647) 391-0872

Appendix C: Screening Survey

Please fill in or highlight your answer, as applicable.

1. Name: _____________
2. Pronouns: ___________
3. Age: ____
4. Are you comfortable conducting this interview in English?
   a. Yes
   b. No
5. Do you identify as Black? (African descent, African Nova Scotian, Afro-Indigenous, Multiracial with Black ancestry, etc.)
   a. Yes
   b. No
6. Do you identify as transgender or gender diverse (non-binary, gender nonconforming, gender queer, etc.)?
   a. Yes
   b. No
7. Do you live in Nova Scotia?
   a. Yes
   b. No
8. Have you had a medical appointment in Nova Scotia in the past 5 years?
   a. Yes
   b. No
9. Please select a pseudonym for written reports of this study, you can choose any name you would like: _________________

Appendix D: Consent Form

Project title: More than Just Words: A Thematic Analysis of Black Transgender and Gender Diverse People's Medical Experiences

Lead researcher: Maya Lowe, MA Health Promotion Candidate, maya.lowe@dal.ca (647) 391-0872

Supervisors
Dr. Matthew Numer, matthew.numer@dal.ca, (902) 494-1153 Dr. Christopher Dietzel, christopher.dietzel@dal.ca

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Dr. OmiSoore Dryden, omisoore.dryden@dal.ca, (902) 494 6516 Dr. Les T. Johnson, lestjohnson@dal.ca

Funding provided by: SSHRC Canada Graduate Scholarship (2021-2022), MSSU Student Award (2022-2023)

Introduction

We invite you to take part in a research study being conducted by, Maya Lowe, who is a master's student in Health Promotion at Dalhousie University. Choosing whether to take part in this research is entirely your choice. There will be no negative impact if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience, or discomfort that you might experience.

You should discuss any questions you have about this study with Maya. You are welcome to ask as many questions as you like.

Purpose and Outline of the Research Study

The purpose of this study is to explore how language impacts the medical experiences of Black transgender and gender diverse adults in Atlantic Canada. Through semi-structured interviews, I hope to learn more about the current state of medical provider's language practices, and gain insight as to how these practices may be improved. Interviews will be transcribed and analyzed using thematic analysis, an accessible approach to identify, analyze, and report patterns in data, guided by Black trans feminism theory.

Who Can Take Part in the Research Study

You may participate in this study if you are:

- Over 18 years old
- Speak English
- Identify as Black (African descent, African Nova Scotian, Afro-Indigenous, Multiracial with Black ancestry, etc.)
- Identify as transgender or gender diverse (non-binary, gender queer, etc.)
- Live in Nova Scotia
- Have had a medical appointment in Nova Scotia in the past 5 years.

What You Will Be Asked to Do

If you decide to participate in this research, you will be asked to participate in an interview either over Microsoft Teams or at a private location of your choosing at Dalhousie University. Potential locations include the Sexual Health and Gender Lab, which has a private and discrete entrance, or a private room in the Killam Library or Collaborative Health Education Building. The interview will be audio recorded and last approximately 45 minutes. During the interview, you will be asked to answer questions about your medical experiences.

Possible Benefits, Risks and Discomforts

Participating in the study might not directly benefit you, but your participation will help us learn more about an under researched area and may benefit others.

The risks associated with this study are minimal; however, discussing negative experiences may elicit emotional or psychological distress. At the end of this consent form, you can find a list of mental health resources to support you and can help reduce distress.

Compensation / Reimbursement

To thank you for your time, we will give you a Visa gift card worth $50. You are not required to complete the interview if you do not feel comfortable doing so, though you would still receive the $50 gift card. If you would like to meet in person and will incur any costs travelling to Dalhousie University, we are happy to cover parking, gas, or taxi expenses, up to $25.

How your information will be protected:

Your participation in this research will be known only to the members of the research team. Any information you share in your interview will only be known to the lead researcher.

Confidentiality

The information that you provide will be kept confidential. Only the lead researcher will have access to this information. All your identifying information (such as your name and contact information) will be securely stored separately from your recorded interview data Interviews will be recorded using Microsoft Teams, and a backup recording will be made on the lead researcher's password-protected phone through the "Voice memo" app which will not be synced to the cloud. The researchers will use their Dalhousie University credentials for the Microsoft Teams meeting, which will ensure that the Teams meeting recordings are securely stored in Canada. During the live Teams meeting, audio and video content is routed through the United States, and therefore may be subject to monitoring without notice, under the provisions of the US Patriot Act while the meeting is in progress. After the meeting is complete, meeting recordings made by Dalhousie are stored in Canada and are inaccessible to US authorities.

The interview data will be de-identified/coded, with the researcher being the only person with access to these codes. Once recordings are transcribed, all identifying information will be removed and transcripts will be coded. We will use a pseudonym of your choosing (not your name) in our written and computer records so that the research information we have about you does not contain your name. I will be the only person with knowledge of these codes. The code guide will be stored securely in a password-protected folder on my password-protected computer. No identifiable data will not be used in publications or presentations. Quotes will be attributed to pseudonyms within the written thesis, and quotes that include potentially identifiable information will be edited to ensure your confidentiality and anonymity. During the study, all electronic records will be kept in a password-protected folder on the researcher's password- protected computer. All paper records will be kept securely in the home of the lead researcher.

I plan to describe and share our findings in a written thesis, presentations, a community consultation, and journal articles. I will report overall patterns and themes that emerge, as well as descriptive quotes from individual participants. A pseudonym of your choosing will be attributed to your quotes. If quotes contain identifying information, this will be removed.

Six months after the thesis is successfully defended, any data you shared within this study will be deleted.

Withdrawing Participation

Before and during the interview, you can withdraw your participation at any time. After interviewing, you have up to 1 month to decide if you want your data removed. During that time, you can decide whether you want any of the information that you have provided up to that point to be removed, or if you will allow us to use that information. After that time, it will become impossible for us to remove it because the data will be analyzed.

How to Obtain Results

We will provide you with a community report of the findings when the study is finished. Study results are anticipated to be ready by the fall of 2023. Any published journal articles from this study will also be sent. You can obtain these results by including your contact information at the end of the signature page. The lead researcher will be the only person with your contact information. You will also be invited to attend a community consultation where the results will be shared and discussed. The community consultation will be hosted at a local café or in a community space. Both participants and non-participants will be invited, including community members, healthcare professionals, relevant scholars, and community workers. If participants attend the event, it would not be known who participated since the data will be de-identified. However, there is a possibility that attendees at this consultation may presume that certain guests may have participated in the research.

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Maya Lowe (at 647-391-0872, maya.lowe@dal.ca) [or Dr. Matthew Numer (at 902-494-1153, matthew.numer@dal.ca)] at any time with questions, comments, or concerns about the research study (if you are calling long distance, please call collect).

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-3423, or email: ethics@dal.ca (and reference REB file # 2022-6350).

Signature Page

Project Title: More than just Words: A Thematic Analysis of Black Transgender and Gender Diverse People's Medical Experiences

Lead Researcher: Maya Lowe, Health Promotion, School of Health and Human Performance, maya.lowe@dal.ca, (647) 391-0872

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in **one 45-minute interview** that will occur at a location acceptable to me, and that this interview will be **recorded**. I understand **direct quotes** of things I say may be used **without identifying me**. I agree to take part in this study. My participation is voluntary, and I understand that I am free to withdraw from the study at any time, until one month after my interview is complete.

______________________________ ____________________________ ____________

Name Signature Date

Please provide an email address below if you would like to be sent a summary of the study results. Your contact information will only be known to the lead researcher and will only be used to share study results and invite you to the community consultation.

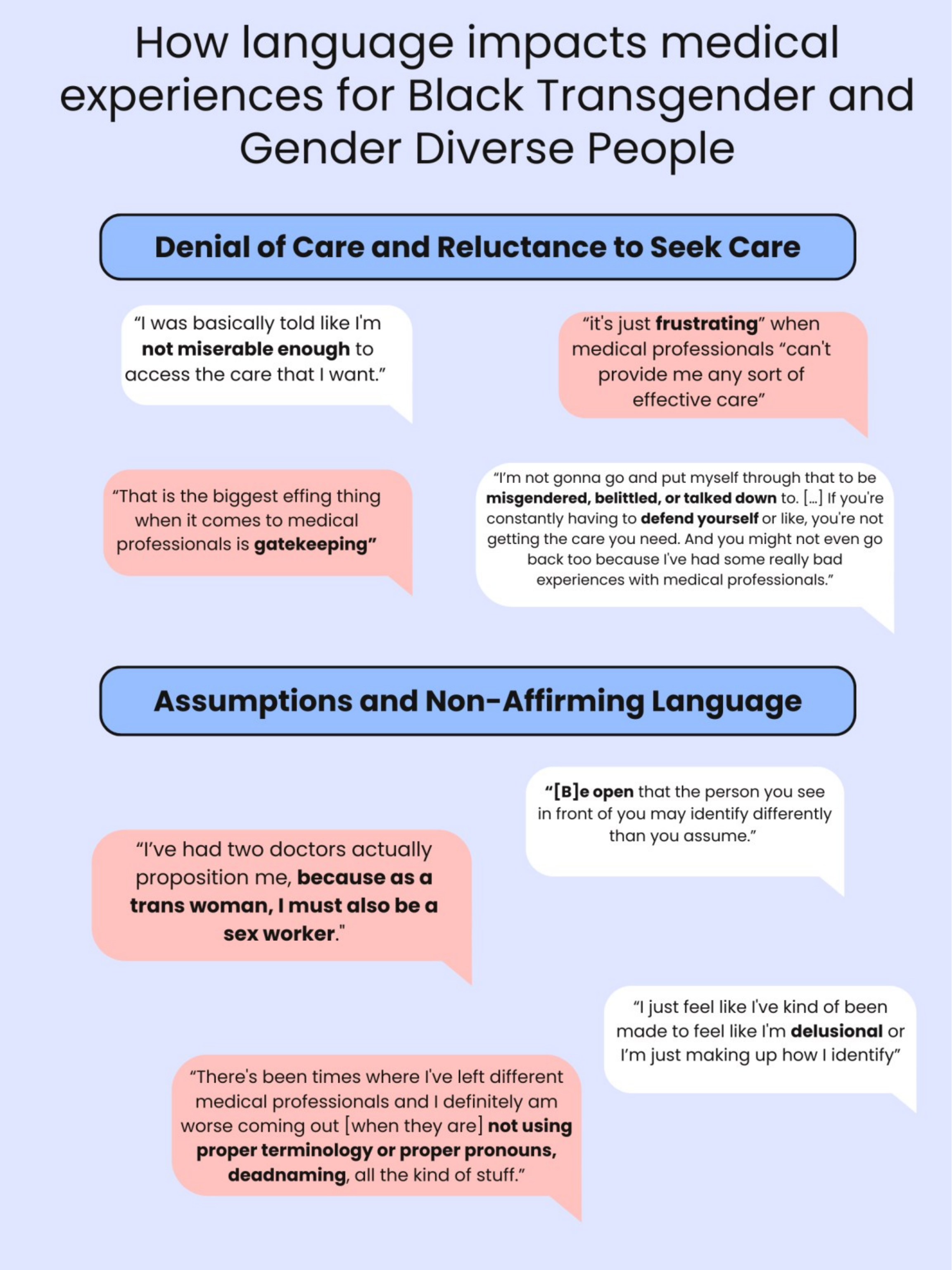
Email address: __________________

Mental Health Resources

- Blackline: 1-800-604-5841
  - BlackLine provides a space for peer support, counseling, witnessing and affirming the lived experiences to folxs who are most impacted by systematic oppression with an LGBTQ+ Black femme lens.
- Trans Lifeline: (877) 330-6366, https://translifeline.org/
  - Trans peer support run by and for trans people.
- FLY 902: https://www.facebook.com/transsupportns/
  - Peer support for transgender adults, free, bi-weekly meetings at the Alderny Landing Library.
- Wellness Together: https://www.wellnesstogether.ca/en-CA?gclid=Cj0KCQjwkOqZBhDNARIsAACsbfIIkxsJNctSzwZ5VtNeujd5xDOhFROTM0vGKdB2Cblh1WmxHNnOif0aAhhDEALw_wcB
  - Online and free mental health and substance use support
- Nova Scotia Crisis Text Line: Text NSSTRONG to 741741

Nova Scotia Mental Health Crisis Line: 1-888-429-8167

Appendix E: Knowledge Translation Materials



How language impacts medical experiences for Black Transgender and Gender Diverse People

Denial of Care and Reluctance to Seek Care

"I was basically told like I'm **not miserable enough** to access the care that I want."

"it's just **frustrating**" when medical professionals "can't provide me any sort of effective care"

"That is the biggest effing thing when it comes to medical professionals is **gatekeeping"**

"I'm not gonna go and put myself through that to be **misgendered, belittled, or talked down** to. [...] If you're constantly having to **defend yourself** or like, you're not getting the care you need. And you might not even go back too because I've had some really bad experiences with medical professionals."

Assumptions and Non-Affirming Language

"[B]e open that the person you see in front of you may identify differently than you assume."

"I've had two doctors actually proposition me, **because as a trans woman, I must also be a sex worker**."

"I just feel like I've kind of been made to feel like I'm **delusional** or I'm just making up how I identify"

"There's been times where I've left different medical professionals and I definitely am worse coming out [when they are] **not using proper terminology or proper pronouns, deadnaming**, all the kind of stuff."

Affirming Language

"If [my doctor] doesn't know something, she has no hesitation of asking me because we have that relationship that **she can ask me anything**. She has no problem with it."

"Having **continuous check-ins** [during a physical examination] was awesome. "

"I just **never felt judged** by her she was always very open and wanted to hear my opinion on things versus just saying all the doctory things and like expecting someone to follow. "

Provider Identity & Communication Style

“I feel just inherently that there would be **less judgmen**t [...] I just feel **immediately more comfortable** even if it's not a Black person just with another person of colour. I feel a sort of **kinship** there versus with white doctors.”

“[H]ow I engage with [my doctor] is very, I would say **cautious** in a way.[...] I shift it in a way that basically isn't how I would speak to someone. Like using more educated language to better describe how I'm feeling from like her perspective. So, I would just say **I'm not myself when I'm communicating with he**r.”

Medicine: Medical Terms, Medical Education, and Medical Training

"You know our feelings are not written in stone and **our experiences are not written in stone.** [...] There are some days that I experience body dysmorphia but there are lots of days that I don't. [...] I don't think it can all be seen so black and white like that."

"I do feel like sometimes as a non-binary person I feel like my dysphoria or euphoria is not as valid as someone that's like a trans man or a trans woman kind of like within that own non-binary category can feel a little bit **pushed to the side**, but I do identify with those terms."

Medical providers often "use very gendered language. Just a lot of male doctors being like '**this is a women's issue**.'"

Medical providers are "**taught through a white lens**, and they give that same advice and education through a white lens."

Recommendations

Medical communities must recognize the diversity among TGD identities.

Primary care reform should consider vulnerable populations like Black TGD people

Patients should be further engaged and empowered in medical settings through shared decision making

The informed consent model should continue to be promoted, evaluated, and updated to best serve patient needs

Medical professional training programs should evaluate compassion and biases throughout the admissions process

Medical providers should learn and use inclusive language in intake forms and clinical practice

Strategies must be employed to increase diversity among positions of power in medical institutions.

Medical professional training programs should continue to increase diversity among learners

Equity and diversity training should be continuously promoted and utilized by medical professionals