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The Role(s) Transgender Adults Want General Practice to Have in Their Healthcare: A Qualitative Study in Southeast England

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Transgender (trans) people experience health inequalities, which includes inequities in accessing and navigating healthcare systems. General practitioners (GP) in England have a limited role in delivering trans-specific healthcare. Few studies have explored what is positively working in GP-led primary care settings and how this can be more widely implemented. This study aims to explore the views and expectations of trans people regarding primary care services. Data were generated using qualitative semi-structured one-on-one interviews conducted with trans experts by experience who were recruited through purposive sampling. Results were analysed and coded using a thematic analysis framework to identify key themes. Positive and negative experiences of accessing and navigating general practice settings were identified by 16 trans people as experts by experience. An overarching theme was for gender-affirming services to be provided through general practice in order to reduce waiting times for specialist care and to move towards an informed consent model of care. Through demonstrating examples of good practice, general practitioners are advised to take a proactive role in providing positive gender-affirming healthcare for trans people. An informed consent model of care should be implemented to improve healthcare access.

KEYWORDS primary care; qualitative research; gender affirming healthcare; transgender; healthcare pathways
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In the United Kingdom, an estimated 600,000 people are trans, although this is likely to be an underestimation (Government Equalities Office 2018). As the sociocultural acceptance of trans people increases, general practitioner (GP) services within primary care are likely to care for an increasing number of trans individuals, who may be seeking advice or support in relation to gender-affirming healthcare (GAHC; Holden and Shrewsbury 2021). Access to GAHC includes interventions such as gender-affirming hormone therapy and gender-affirming surgery. A holistic approach should be taken whereby all trans individuals can choose to access any, or none, of the gender-affirming interventions available to them. This is irrespective of having a “binary” or nonbinary identity, co-occurring disability, or neurodivergence.

Through the National Health Service (NHS), access to GAHC is initially through primary care, in particular general practice, where the GP coordinates referrals to a gender identity clinic (GIC; NHS England 2019). At GICs, individuals are assessed by a psychiatrist to obtain a diagnosis of gender dysphoria, following which individuals may be referred for state-funded interventions such as hormone therapy, gender-affirming surgery, vocal coaching, fertility preservation and psychotherapy. The foundation of this model relies on the psychiatric assessment of trans individuals. Waiting times for GICs are extensive, with waiting times for an initial appointment in England reported between 26–74 months, with significant regional variation between GICs (Gender Construction Kit 2023). For comparison, the NHS referral-to-treatment waiting times at the end of April 2023 showed that of 7.4 million people awaiting to commence treatment, only 5% and 0.01% respectively were waiting more than 12 and 24 months for treatment (National Health Service, 2023). Consequently, many trans individuals’ access GAHC privately or through self-medication (Ellis, Bailey and McNeil 2015, White et al. 2023). The limited availability of services and regional variation in service provision has been associated with travel costs and variability in the quality of care (Heng et al. 2018).

Trans people in the UK report a high rate of mental illness, including suicidal ideation, that can be attributed to discrimination, transphobia, and delays in accessing GAHC (Bachmann and Gooch 2018; Jones et al. 2019; Wright et al. 2018). Common experiences within primary care include GPs being unwilling to provide or support access to GAHC (Harrison et al. 2020; Snelgrove et al. 2012). The Trans Lives Survey 2021 found 57% of participants avoided healthcare settings when unwell, with 14% being refused care by a GP on account of being trans (TransActual 2021). Refusal by GPs to acknowledge the presence and healthcare needs of trans people adds to a collective sense of distrust by trans people accessing GAHC in the UK.

The role of primary care and, in particular, the GP in GAHC has evolved in recent years. The General Medical Council (2023; GMC) has guidelines for GPs in prescribing "bridging hormones" as part of a harm-reduction strategy whilst trans people are awaiting GAHC, supported by the Royal College of Psychiatrists and the World Professional Association for Transgender Health (Coleman et al. 2022). In addition, there have been several pilot projects providing GAHC access from a primary care-led perspective. These services are locally commissioned to provide assessments for gender dysphoria and services such as speech and language therapy, psychological support, referrals for hormone therapy, surgery, fertility preservation and hair-reduction. These include the Sussex Gender Service (Sussex), the Indigo Project (Greater Manchester), CMAGIC (Cheshire and Merseyside), Trans Plus (London), and the East of England Gender Service.

Trans communities have suggested establishing an informed consent model would improve access to care (Ellis et al. 2015; Schulz 2018; White et al. 2023). Informed consent emphasises self-determination for trans people and shared decision making between the healthcare practitioner (HCP) and trans individuals (Spanos et al. 2021). Following the principles of informed consent, trans individuals should be able to access GAHC so long as the associated risks and benefits of any intervention(s) are clearly understood, and the individual has capacity to consent. This is irrespective of whether any specific "gender transitioning" milestones have been met, or a GD diagnosis given, that would grant state-funded access to GAHC through a medical model. This would involve GPs having a more direct role in providing GAHC through localised, community-based services. With regard to this, the World Health Organisation (WHO) declassified being transgender as a mental or behavioural disorder in the International Classification of Diseases, 11th edition (ICD-11) in 2019 (Coleman 2022). There is now no basis for trans people to undergo psychiatric assessment and medical systems should be reformed as they are upholding a now outdated presumption and diagnosis (Allory 2020; Askevis 2019). By eliminating the requirement for a psychiatric diagnosis and assessment, primary care-led services could support the depathologisation of trans identities in favour of self-determination (Ashley 2019).

The aim of this study is to gain a better understanding from trans people, as experts by experience, into what GPs and other primary care services have done well and how this can be applied elsewhere. A secondary aim of this study is to gain more of an understanding of what trans people want their healthcare to look like, what areas of GAHC could be provided within primary care, and how GPs can implement or support this from a patient's perspective.

METHODS

This qualitative interview study was developed as a result of steering group discussions regarding the locally commissioned service for trans healthcare (Sussex) about the increased need for academic research around GAHC and primary care for trans patients locally across the Sussex, UK region. A Sussex-based trans support organisation was approached for advice and support. A trans senior worker at the organisation (LW) designed and led the project. The research team also included two cisgender senior academics (CDL, MP) who supported with securing ethical approval, funding and overseeing the research process. A medical student (DH) was invited due to their previous postgraduate research on trans experiences of primary care (Holland et al. 2023). LW and DH took part in data collection and analysis and were both financially compensated for their input. All members of the research team were white and British. The team included researchers of a range of ages, and those who were queer and/or disabled and/or neurodivergent.

Study Design

A qualitative study was carried out using one-on-one semi-structured interviews with trans individuals within the southeast of England. Research was conducted and reported in line with the consolidated criteria for reporting qualitative research (COREQ; Tong 2007).

Sampling and Eligibility Criteria

Purposive convenience sampling was used to capture a range of views across people of different ages, genders, and racial identities. An aspirational quota was set to recruit greater than or equal to two trans people that were: older than 50 years, people of colour, transfeminine, transmasculine, nonbinary, and disabled and/or neurodivergent. "Transfeminine" here includes those who use the labels woman, trans woman, transfemme, or similar. "Transmasculine" includes those who use the labels man, transman, transmasc, or similar. We sought in the range of 10–15 participants for sufficient information power given the topics of interest and analysis (Malterud 2016). Participants were eligible if they were above 18 years old, trans, and eligible to receive healthcare across East and West Sussex. Exclusion criteria included those who could not speak English and/or could not give informed consent, whether verbal or written.

Recruitment and Procedure

Participant recruitment was facilitated by the trans community researcher (LW) working within the trans community. Advertisements were distributed to local charities and Sussex-based community organisations, as well as through the research team's social media. Individuals were invited to contact members of the research team via email. All prospective participants were distributed a consent form and a participant information sheet prior to interview. All participants were given the option of having a trans interviewer and a choice of online (via encrypted Zoom) or face-to-face interviews. It was emphasised that participation in this project had no influence on the support they received from any community organisations or from primary care services. Neither members of the community researcher's immediate personal network (i.e., friends and colleagues) nor individuals receiving individual support from them in a professional capacity participated in the study. Further purposive sampling of those with multiple marginalised identities was restricted by the time constraints of the project.

Interviews and Data Collection

Semi-structured interviews were designed and conducted in accordance with the process as set out by DeJonckheere and Vaughn (2019). Semi-structured interviews took place between October 2021 and January 2022. The two interviewers were DH and LW. Both interviewers were previously trained in qualitative methods. Both interviewers pilot tested the interview prior to the study to ensure there was a shared understanding between the interviewing team as to what type of language and interview style should be used.

Each interviewer conducted eight interviews each. At the interview, first demographic questions were asked before the consent form was read through with the participants. The audio recording was then switched on where participants were asked to state if they had read, understood, and agreed to the consent form. The maximum time for interviews was set to 60 minutes to support accessibility for disabled participants and researchers. All the interviews were digitally recorded and transcribed verbatim by hand using Microsoft Word by DH. Participants were assigned pseudonyms that were gender-neutral or in keeping with the common gendering of their names.

Ethical approval was granted by the Brighton and Sussex Medical School Research Governance and Ethics Committee on 27th October 2021 (ref no: ER/BSMS9923/1). All participants received a love2shop voucher of £20 for participation.

Topic Guide

Interviews were guided by a topic guide developed by the community researcher. The final version was pilot tested with DH and LW. Demographic questions were asked regarding participant's age, racial identity, their gender/relationship to gender, and whether they had a disability or were neurodivergent. The following domains were included in the topic guide: experiences of accessing GAHC; the impact of GAHC on health and wellbeing; views on the current GAHC pathway; and the role of the GP in GAHC—encompassing their views on what changes could be made to the current standard model of care. The topic guide had predetermined open-ended questions including: "What examples of trans affirming healthcare have you experienced in Sussex?" and "What impact has accessing gender-affirming healthcare had on your overall health and wellbeing?" Data collated through these interviews exploring the impact of the mixed provision of GAHC on the mental health of trans individuals has also been published (White et al. 2023). The topic guide had suggested additional follow-up questions and prompts to support the interviewers and ensure a similar, consistent approach across interviews.

Data Analysis

The data was analysed using the Ritchie and Spencer (1994) thematic framework analysis in six stages: familiarisation; coding; searching; reviewing; and defining themes; and reporting. Data analysis was conducted manually and independently by DH and LW. The coding framework and interpretation of results were discussed amongst the two researchers to establish a consensus. DH led in indexing and charting the data; LW and DH then began the interpretation process by exploring patterns in the data to extrapolate key themes. Interpretation of the results were discussed with the wider research team to reach a consensus and validate the findings.

RESULTS

Twenty-one people contacted the research team. Sixteen were included in the study (Table 1). Two did not respond to email regarding an interview, one did not attend the interview, one dropped out of the study prior to interview, and one contacted the research team after we had ended participant recruitment. Interviews conducted had a duration of 31–74 minutes, with a median time of 50 minutes.

The aspirational quota set was met in recruiting participants in the following categories: trans feminine; nonbinary; disabled and/or neurodivergent. A significant proportion of participants were either white and/or trans feminine and/or 18–39 years of age. Further purposive sampling of communities of colour would have been preferred, however the research team were restricted due to time constraints.

Due to the richness of the data acquired and the separate research questions addressed, two papers resulted from this dataset. The first paper focuses on the mental health impact of current GAHC pathways in Sussex (White et al. 2023). The data contained in this paper focuses on the experiences and expectations of primary care and broader healthcare services, from which two key themes were identified: (1) trans experiences of accessing healthcare and (2) the trans-specific healthcare pathway. Key sub-themes are expanded upon below.

Transgender People's Experiences of Accessing Healthcare

General Practitioner (GP) knowledge

Participants described a range of positive, negative, and neutral experiences across primary and general healthcare. There were various factors which influenced how these experiences were perceived by respondents. GPs being knowledgeable about trans-specific healthcare positively shaped the outcome of the consultation. This included having a GP that had supported trans patients before, understood GAHC pathways and what services GPs could provide, proactively sought to acquire further knowledge, and/or understood the practicalities and limitations of accessing GAHC in England.

> The best interaction in that I was getting valuable information, she's [the GP] obviously extremely well informed about trans healthcare and … also approaches it in a very practical manner, like understanding where the healthcare system fails trans people a lot. A lot of us turn to self-medicating and things like.
>
> –Matthew

A GPs proactiveness and willingness to learn were facilitators towards having a positive healthcare encounter, including advocating on behalf of the patient. However, participants described an initial apprehension to accessing primary care services due to the level of uncertainty around GPs understanding of GAHC.

> Going to the doctors for one thing, which is something I felt uncomfortable about in the past… knowing that I have a GP who's friendly and listens to me and, you know, in a general sense, in a trans sense, who respects my identity, as well, as far as I can tell. Like, it makes me feel a lot more able to engage in healthcare and without that … there's a good chance I think that I would withdraw a lot more and … possibly allow

Table 1. Participant demographics (*N* = 16)

Characteristic	*n*
Age (years)	
20–29	7
30–39	5
40–49	2
50–59	2*
Ethnicity	
White	15
Black / Person of colour	1**
Gender	
Trans woman / transfeminine	10*
Nonbinary / genderfluid	3*
Trans man / transmasculine	2*
"Unsure" / "still figuring it out"	1
Disability / neurodivergence	
Yes	9*
No	6
Prefer not to say	1

Note. *aspirational quota met; **aspirational quote not met

> healthcare issues to build up rather than say, deal with a GP who is not particularly respectful or acknowledging of my trans identity.
>
> –River

Anticipation of a negative healthcare interaction was not uncommon, especially when there had been previous negative experiences with a GP:

> Well, back in [location], what, I came out 2018? I had a very nice GP there who—she was just very nice and treated me like a normal person, which is always nice compared to like a GP I had before who would kind of just like look me up and down and make very objectifying observations.
>
> –Jamie

GPs who had this knowledge base were better able to establish rapport and provide holistic support. This benefits trans patients in the short-term and fosters an environment where they feel as though they can return to a GP they trust, for both trans-specific and general healthcare. Participants who anticipated, then experienced, discriminatory attitudes, had their feelings of anxiety reinforced and associated with accessing healthcare. These negative interactions had a long-lasting impact where some participants were subsequently avoidant of accessing general healthcare; it was perceived as more harmful to their wellbeing.

> My GP isn't so good. They're a bit old-fashioned. It's a little bit of a—it's quite a trigger when I go there. It's like, what's gonna happen today? Are they gonna be misgendering me in public?
>
> –Candice

Some GPs continued to reinforce cisnormative gender stereotypes, to the extent some participants altered the way they dressed to better access GAHC without being challenged by GPs. Additionally, some participants recounted having been asked invasive personal questions, unrelated to their health, that were used by the GP to justify access to secondary care services.

> To get on the GIC list I had to write a statement explaining why I felt that—you know, why I feel I was transgender and why I was seeking, you know, access to GIC. And basically, the GP told me that I needed to explain everything including, you know, my sex life and everything and that was very dehumanising to put that on paper and putting it on paper was, was very hard.
>
> –Alex

Participants often felt forced into the role of patient educator, which ranged from educating GPs about trans identities to guiding GPs through GAHC guidelines, prescribing, and monitoring hormones and making referrals to secondary services.

> I have to put time and effort into something that, really, I shouldn't have to do anything. It should be all on them. I mean, having to learn about dosages and names of certain drugs to tell my doctor what—I shouldn't have to tell them what I should be getting prescribed. They're a doctor. They should tell me. It's crazy.
>
> –Candice

Some participants felt as though they had to prove they were "trans enough" to GPs as a prerequisite of accessing GAHC. This was also seen as GPs prioritising the potential political ramifications of providing GAHC above the welfare of trans people. This posed additional struggles for some participants who were nonbinary or gender-nonconforming; whose gender identity and/or expression directly challenged GPs assumptions as to what GAHC "should" look like.

> I mean, as a gender-nonconforming person, as somebody who, like, I don't—personally, I don't wanna have surgery, I don't want hormones... And I think, yes, a lot of trans people do want surgery, want to go on hormones, trans people do wanna have surgeries, but I think there's almost a pressure to prove that you're trans enough? That you kinda have to want those things in order to be considered trans?
>
> –Kai

Furthermore, some participants had difficulty defining key positive or negative healthcare encounters, but rather described their experiences as an absence of overt negativity:

> Like, [the GP] still got my pronouns wrong, but at least he didn't call me miss or madame or lady.
>
> –Kai

Many participants attributed limited GP knowledge to a lack of training regarding GAHC. The need for training was especially expressed in the context of increased waiting times for specialist care, meaning that the GP may be the only point of contact for support for many years. However, there was a perception that some GPs were unwilling to educate themselves about trans-specific healthcare and take responsibility. One participant described moving to a different surgery to access bridging hormones and reaching out to their former practice:

> [The former GP] wanted his details from me, so that then she could refer anybody like me in the future to him, because that got her—that was a nice easy way for her to get off the hook for having to deal with anybody about bridging hormones. And I said, "well, do you wanna use me as a case study and work with [current GP] on this so you can get some training and some help and so that people like me in [location] can come to you and it will all be fine and you'll be able to prescribe bridging hormones and you can change your policy.?" No, no.
> –Jo

This demonstrates there may be discriminatory behaviour within primary care through a reluctance to engage with trans individuals and through maintaining ignorance, despite awareness of training opportunities.

The patient-practitioner relationship

Participants' experiences of primary care were influenced by a perceived affirmation or rejection of their gender identity. Having a non-judgmental GP was regarded highly by respondents, with examples of gender affirmation including using the correct name, pronouns, and ensuring patient documentation reflected as such. Some participants described their expectations of ideal care as being able to take part in shared decision making that was more collaborative than hierarchical in nature.

> I find that what's very important for me … in my relationships with healthcare professionals is that the relationship is not a kind of paternalistic [one]… I contrast that with healthcare professionals who have a more collaborative approach who can—like, there is an equality to the relationship of sharing of their skills and knowledge with my knowledge of my body and desire to what health actually means in my life.
> –River

If expectations of ideal care describe a deconstruction of power imbalances traditional within general practice, recognition is needed of the ways GPs hold power, on both a systemic and individual level. By being a common first point of contact for trans individuals, GPs can have a gatekeeping role in who gets access to specialist care. Some participants described a fear of disclosing health concerns unrelated to their gender identity for fear of their GIC referral or access to GAHC being taken away. This was more common amongst participants with multiple marginalised identities, especially those who had mental health issues, disabilities, or were neurodivergent.

> I haven't disclosed any of my disabilities or mental health issues to the gender identity clinic cause I'm aware that they are much less likely to allow me to continue along the medical path I've gone down. It's also prevented me from getting myself properly tested for autism… 'cause I know it might make it harder for me to continue to procure hormones if I do so.
> –Sam

On an individual level, some participants described feeling as though their health was not taken as seriously, and the GPs' lack of understanding meant their wellbeing was being disregarded.

> It makes me feel quite down and quite, kind of, not being heard… You know, if I went to the doctors and said, "my arm has been hurting for years, could you help with my arm?" they'd go, "yeah I'll help you with your arm." But if I say "my gender's been hurting for years/ can you help my gender?" they just kinda go "meh, whatever."
>
> –Kai

This demonstrates how important it is for trans people to feel as though they have greater agency in their own healthcare in equal partnership with a GP. It is important for GPs to recognise that trans people may be experiencing anxiety relating to previous or anticipated negative healthcare interactions. Being proactive in addressing possible concerns may help to increase trust and foster a more positive patient-practitioner relationship.

The Trans Specific Healthcare Pathway

The role of primary care in GAHC

A general perception amongst all participants was that GAHC should be primary care led. This included initiating hormone therapy and making referrals for fertility preservation, vocal coaching, laser hair removal, and both general and gender-based counselling. Participants felt better able to make informed, autonomous decisions about their healthcare in primary care, in collaboration with their GP.

> I think the main positive experiences I've had is, like, being able to have an informed consent with a GP who has let me—he's given me suggestions for what I can do with my hormones without being strict on it, if that makes sense… I've just felt like I have a lot of control and options over it that have made it a much better experience for me.
>
> –Sophie

Primary care-led services were perceived to be associated with a decreased waiting time compared to accessing GICs. Additionally, primary care was regarded as more accessible, with less travel requirements on the individual to access care.

> There should be more, like, decentralisation of services so that the GPs have more power to get people directly onto what they need and, like, I don't know—I feel like if you're piling up all the services in a couple of central gender clinics around the country, it just, like, makes there be so many waiting lists and stuff. And, like, I get that that's probably how the legal system in the UK has set it up so that fewer trans people can get onto healthcare because that's kinda what they want.
>
> –Gemma

Concerns were noted around the feasibility of GPs being able to provide GAHC. However, some participants expressed that by having more primary care-led services, GAHC may be regarded as less "niche" and GPs can take more direct responsibility for patient care and services they may eventually provide regardless.

> At some point, even if you go through the GIC process, you get discharged from the GIC, and the ongoing management of your hormones for the rest of your life falls to your GP, so if they can do it then, why do I need someone else to hold their hand to start with?
>
> –Emily

There were mixed experiences of participants already accessing some GAHC services across primary care. Some participants described being started on bridging hormones and being followed up for regular blood tests and monitoring by their GP. Some participants also reflected on their experiences trying to access fertility preservation on the NHS. None of the participants had accessed state-funded fertility preservation through primary care. However, some described their GP actively advocating on their behalf to local clinical commissioning groups or completing funding applications for those self-funding.

> My advocate was brilliant and worked with trans people before and was really sensitive—just very kind of consensual about how every stage—and really, yeah, did the legal research to kind of advocate on my behalf to the NHS about why I should be able to receive hormone replacement therapy—sorry, fertility preservation—on the NHS prior to hormones.
> –Melody

Allocating more services to primary care was therefore seen as an extension to care currently offered.

> He [the GP] also referred me for voice therapy, which I had no idea... Making more people aware that they can get that through their GPs is really important.
> –Sophie

A key priority for many participants was accessing hormone therapy and a GPs ability to initiate and monitor as such was regarded highly. There were mixed responses regarding surgical referrals within the remit of primary care. For some participants, surgical referrals were within the remit of the GIC as they were perceived as requiring more specialist input from secondary care. However, there was significant frustration with the current model of care, primarily the requirement for psychiatric assessment prior to being referred for state-funded surgery, and general waiting times. Moreover, some participants who thought surgical referrals should be GP-led associated as such with a shorter waiting time and greater accessibility.

> It was annoying that I couldn't get my first appoint to see the surgeon until I'd actually got those two referrals [from psychiatrists] … I would have liked to have had the opportunity to see the surgeon sooner.
> –Emily

The role of the GIC and specialist services

There was a collective preference for an informed consent model in GAHC. Some participants expressed that, whilst the majority of GAHC could be primary care-led, there be circumstances whereby more specialist input could be required. Examples given included the potential need for endocrinological input when an individual does not respond to hormone therapy in a typical manner, the continued need for specialist surgical input, and the role of psychiatry in providing additional support to trans individuals with co-occurring severe mental illness.

> It's all a bit bonkers, but we should be able to self ID. If we were, then the GIC would—literally all they would need to do is some mental health support, some hormone support for GPs in more serious cases in things, where it gets beyond the GPs knowledge, and surgery. That's

> it. They should be doing surgery referrals. That's basically all we need the GIC for.
>
> –Ellie

The majority of participants wanted gender-affirming hormone therapy to be initiated through primary care. However, some participants wanted more of an opportunity to discuss their healthcare with an endocrinologist, particularly to discuss hormones, side-effects, and other considerations, such as fertility preservation treatments.

> I think there should be… some kind of discussion you would have to have with maybe an endocrinologist explaining exactly what the effects will be, like explaining possible fertility treatments you can take beforehand.
>
> –Sam

Another view was that gender specialists should be located across different hospitals with more dispersed clinics, similar to secondary care services, and this would be more locally accessible.

> Well, I think there should just be gender specialists. I'm not sure there needs to be a gender clinic. I think if, you know… an ear, nose and throat specialist or… whatever you've got wrong with you in the health service, there's a specialist in every hospital, isn't there?
>
> –Jo

Overall, trans individuals wanted to feel as though they were receiving practical advice and support rather than being psychologically assessed. Many participants felt as though this could be delivered through primary care where the GP was fully informed in GAHC pathways.

DISCUSSION

Trans people experienced difficulties at all stages of healthcare access. The way GAHC is currently accessed in England is described by the participants as having a multitude of failings. These failings are putting the physical and psychological wellbeing of trans people at significant risk. There was an overall negative perception of accessing GAHC through primary care services and GICs with some positive experiences on an individual basis that speaks to systemic failings in GAHC provision. Additionally, recognising a good quality of care may be difficult in an environment where trans people anticipate negative reactions from healthcare providers and/or having to act as patient educator.

This is one of few studies to explore specifically positive experiences of GAHC access in primary care within the NHS. Previous studies have explored general healthcare (Heng et al. 2018; Teti et al. 2021), mental health (Ellis et al. 2015; Valentine 2018; White et al. 2023), GICs (Ellis et al. 2015; Taylor 2019), or experiences of healthcare in a non-NHS setting as a focus (Carlstrom et al. 2021; Guss et al. 2019; Ross et al. 2016). Participants from this study were additionally more likely to have accessed GAHC, such as bridging hormones, from primary care services, for which there are few studies, due to this region specifically having a Transgender Locally Commissioned Service (Sussex CCG 2021).

Multiple factors contributed to the difficulties accessing GAHC, such as a lack of GP knowledge regarding trans identities and healthcare needs, which corroborates findings from previous research. This includes anticipation of negative healthcare experiences and subsequent avoidance behaviour (Adams et al. 2013; Heng et al. 2018; Lerner et al. 2017). An additional study reported that trans individuals who had not accessed gender-affirming medication, such as hormone therapy, were more likely to experience distress discussing GAHC with their primary care doctor, including trans individuals who had no plans to seek medical intervention (Bauer, 2015). This was reflected by comments from participants of this study, where anxiety and stress stemmed from an anticipated rejection of their gender identity by GPs on the basis that they may not meet GPs preconceived ideas of what "counts" as being trans. For GPs, these preconceived ideas may be based on arbitrary social and/or medical transition "milestones," centred around the current model of care and requirement for a diagnosis of gender dysphoria, to access GAHC in England (NHS England 2019). The current NHS pathway for accessing GAHC does not reflect the diversity of gender identities and expression of trans people.

Many participants in this study reported negative experiences within primary care, which suggests a high prevalence of negative healthcare encounters. This is supported by the Trans Lives Survey 2021, where 70% of respondents reported transphobia when accessing healthcare (TransActual 2021). Regarding GICs, significant waiting times had a detrimental impact on participants health and wellbeing, which is reflected in trans peoples' broader experiences of GICs in the UK (Ellis 2015; McNeil et al. 2012).

The current model of care is perceived as paternalistic and pathologizing. This supports previous studies which have shown a general distrust of HCPs amongst transgender populations and a fear of disclosing physical and mental health concerns should they be used to deny access to GAHC (Ellis 2015). Previous research corroborates these findings that a supportive GP instils trust and improves mental health outcomes (Heng et al. 2018; McNeil et al. 2012).

Positive experiences and suggested solutions largely centred around themes of informed consent, self-determination, and working collaboratively in partnership with GPs. Under the current system in the NHS, participants emphasised proactivity and advocacy as a way GPs can have a large positive impact. This goes beyond an awareness of GAHC pathways but a knowledge of how to advocate and support trans people awaiting GIC appointments, including prescribing and monitoring bridging hormones and engaging with local transgender communities on how to improve GAHC access on a local and regional level.

With regards to expectations of ideal care, trans people wanted GPs to have a more involved role in GAHC service delivery. This is supported by frameworks as set out by the World Professional Association for Transgender Health (WPATH) which approves of an informed consent model as an alternative to required psychological assessment (Coleman et al. 2022). Studies evaluating pilot projects involving an informed consent model have generated high patient satisfaction rates (Ker 2020; Spanos et al. 2021). Whilst these pilot projects took place in Australia and New Zealand respectively, the findings from the studies showed participants associated these primary care-led services with increased accessibility, decreased waiting times and an overall depathologisation of trans identities; all themes which were associated with GP-led GAHC provision by participants in this study.

The requirement for trans people to undergo psychiatric assessment is rooted in supporting an outdated presumption and diagnosis (Coleman, 2022). As reinforced by the participants in this study, the current system requiring diagnostic assessment for GD furthers waiting lists, delays healthcare access and contributes to feelings of distrust and negative experiences within healthcare for trans people.

Primary care led GAHC was associated with greater accessibility, particularly for disabled, neurodivergent and/or working-class participants. This supports previous research highlighting geographical and socioeconomic inequality in accessing GAHC under the current care model (Heng et al. 2018). However, cisnormative attitudes in primary care isolated trans people, more so if they had other marginalised identities, emphasising the continued need for training amongst primary care staff. In particular, previous studies have shown racial discrimination negatively impacts healthcare outcomes for trans people of colour (Agenor et al. 2022; Howard et al. 2019). However, due to the low number of participants who were trans people of colour in this study, the additional impacts of racial biases were unable to be commented on.

The attitudes of GPs towards primary care-led GAHC services are mixed. Studies focusing on primary care-led GAHC services under an informed consent model have shown these services to be seen widely more positively, both from trans patients and clinicians (Reisner et al. 2015; Schulz 2018). There have been concerns expressed by some GPs about providing GAHC, seen as more "specialist" and thus beyond the remit of general practice (Crowley and Lacey 2021; Royal College of General Practitioners 2019). However, both the GMC and the Royal College of General Practitioners have published guidance and training modules available on GAHC and supporting trans patients under the current GAHC pathway (General Medical Council 2023; Royal College of General Practitioners 2019). Additionally, as expressed by many of the participants in this study, GAHC such as prescribing and monitoring hormones is the eventual responsibility of the GP following initiation of treatment through the GIC. Moreover, the generalised view of GAHC as "niche" may work to discriminate against trans people, as these views can be used by GPs to disengage with trans people entirely, including in the refusal to acquire additional training to meet the health needs of trans people.

Overall, normalising GAHC using a primary care-led informed consent model would depathologize trans identities. Trans individuals will be able to self-identify rather than having to prove their gender identity to GPs with cisnormative assumptions as to what it means to be trans. This is likely to increase the number of positive healthcare experiences trans people have in accessing GAHC. This is likely to improve the mental health of trans people in England but also individuals' overall health, as they are less likely to avoid general health services due to previous negative healthcare interactions.

Strength and Limitations

To the best of our knowledge, this is one of the first studies focusing on the positive experiences and expectations of primary care amongst trans individuals in England at a time when the introduction of the new NHS integrated care systems (ICS) may bring opportunity to reconfigure and commission new services. A key strength of this study is that it was co-produced and co-led with the trans community. This research also gave an opportunity for trans participants to express their ideas as to what they want GAHC pathways to look like in England through the publication of these findings.

The local Sussex NHS commissioning service has contributed to the training of local GPs in supporting trans patients in accessing healthcare. Therefore, this population group may have been more likely to have experienced both, or either, primary care led GAHC and/or standard referral to a GIC through the NHS (Sussex CCG 2021).

The sample used for this study was modest and self-selecting. The findings may have been strengthened from additional quantitative analyses exploring positive and negative experiences of primary care. The majority of participants were white and trans feminine which means valuable insights from people of colour and transmasculine people were missing from these data. Further purposive sampling of under-represented groups may have been achieved through a longer recruitment time. The community researcher was known by some of the participants as having a combined role as researcher, trans community member and worker at a trans support charity, which may have introduced participant bias and influenced some participant's responses. Their involvement may have served to increase participant trust in the project. To navigate this, close personal contacts and those receiving individual professional support from the community researcher were not included, and where possible the least known interviewer for each participant was chosen.

Implications for Clinicians and Policymakers

The role of the GP has been ill-defined in the context of delivering comprehensive trans specific healthcare. This continues to illicit confusion as to what trans people can expect from their GP and what care GPs understand they can provide. GPs should be made aware of the barriers and facilitators to accessing GAHC in England and their role in supporting trans patients. Under the current system, ways in which GPs can have a positive impact are through affirming one's gender, being aware of the GAHC pathway, and being proactive by signposting to relevant support services and taking additional training opportunities. GPs should be able to offer, or support early access to, hormone therapy, vocal coaching, laser hair removal and fertility preservation. This is not only in line with guidance from WPATH, but would also substantially improve trans people's mental health, especially when on extensive waiting lists under the current healthcare pathway.

Many participants accessed GAHC through private healthcare channels or through self-medicating. This creates a significant socio-economic class divide in who has access to GAHC (White et al. 2023), further exacerbated by the fact that trans people are at higher risk of homelessness and poverty (Government Equalities Office 2018; White 2015). Financial stress had a significant impact in participants lives, where continuing treatment may come at the expense of living or eating well. GPs are advised to be aware of ways to support trans individuals accessing GAHC. This may include signposting to local community support services or advocating on behalf of patients to access specialist services, such as enquiring to local clinical commissioning groups to fund fertility preservation.

On an institutional level, policymakers should consider moving away from psychiatric assessment as a precursor to GAHC access and implement an informed consent model of care in line with WPATH guidelines. This involves removing the need for a diagnosis of "gender dysphoria" or psychological evaluation to access GAHC. Trans people should be able to access early GAHC from their healthcare provider having understood the benefits and risks of any interventions. The development and evaluation of new ICS should be informed and evaluated by a representative sample of the trans community.

Areas for Future Research

Recommendations to improve access to GAHC in primary care can be evaluated, which may contribute to a growing body of evidence behind what influences positive healthcare experiences in primary care settings. Further research may include the perspectives of GPs in the facilitators and barriers to providing GAHC. Further research is needed as to the experiences of primary care by trans people with multiple marginalised identities in England, to ensure their voices are heard in commissioning and developing ICS using an intersectional framework. Additionally, there is limited research comparing the experiences of GAHC access both across different UK nations and between different regional locations in England.

CONCLUSION

There were difficulties in accessing GAHC by trans people that need to be addressed on an individual, institutional, and societal level. The experiences and expectations of trans people suggest healthcare provision should be more primary care led under an informed consent model. The current system by which GAHC is accessed in England is harmful to the health and wellbeing of trans people. There is a duty of care for GPs to be aware of trans-specific healthcare needs and take responsibility in advocating for trans patients, providing additional holistic support and advancing their knowledge.

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