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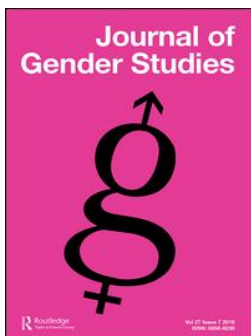
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# For whom is ignorance bliss? Ignorance, its functions and transformative potential in trans health

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## ABSTRACT

Trans people face biases and barriers in healthcare including health professionals' lack of training and knowledge of trans health, bodies, and identities. Interactions between health professionals and trans people have been analysed as a site fraught with historical power imbalances, epistemological struggles that position trans people at a disadvantage and one where negotiations of access to adequate services and treatment continue. In this paper, I highlight the need to pay attention to not only how knowledge about trans bodies and possibilities is produced, negotiated and contested, but also to moments of claimed and/or actual ignorance that take place in healthcare. Applying a feminist epistemological lens, I ask what is at stake and what is the function of ignorance in the trans patient/health professional relationship. Such exploration is crucial if we recognize that practices of ignorance are often entangled with practices of exclusion and oppression. Methodologically, I draw on qualitative in-depth interviews with 18 health professionals in the UK conducted as part of a larger research project on trans health. In analysing the multi-faceted manifestations of ignorance within the data and linking them to feminist taxonomies of ignorance, I explore how ignorance can be critiqued and transformed.

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Trans health; knowledge production; ignorance; feminist epistemology

## Introduction

For trans people, healthcare is a site particularly fraught with historical power imbalances (Davy, 2010, 2015; Pearce, 2018; Vincent, 2018).<sup>1</sup> The history and epistemology of trans health remain entangled in professional medical discourse with 'a professional class of gender identity experts, who may act as gatekeepers for trans-specific healthcare' (Pearce, 2018, p. 27). Gatekeeping access to gender affirming care also takes place outside of specialist gender identity services (see, for example, The Women and Equalities Committee, 2016; Whitehead, Thomas, Forkner, & LaMonica, 2012). Whilst a shift away from pathologising understandings of gender diversity can be observed (Hilário, 2018; Reisner et al., 2015), the move towards affirming, consent-based models of trans healthcare has been slow, uneven, and marked by an ongoing tension between the push to depathologize and the role of clinical knowledge and expertise (Pearce, 2018, p. 26–26). Trans experiences and identities remain subjects of medicalization (Johnson, 2019) and at times pathologisation within healthcare settings (Hilário, 2018; Mizock & Lundquist, 2016).

It is in the context of this central role health professionals play – and epistemic privilege they possess – in trans health, that paying attention to their knowledge, as well as to moments of

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ignorance, becomes important. The mapping of significant and persistent ignorance around trans identities and trans health by health professionals points to what is often framed as *knowledge gaps* on the part of this group (Bauer et al., 2009; Benson, 2013; Davy, 2010; Ellis, Bailey, & McNeil, 2015; McPhail, Rountree-James, & Whetter, 2016). At the same, the different *kinds* of ignorance remain unexplored. Yet, as feminist and critical race epistemological interventions have demonstrated, practices of ignorance are often entangled with practices of exclusion and oppression; ignorance is not merely a feature of neglectful epistemic practice but rather a 'substantive epistemic practice in itself' (Alcoff, 2007, p. 39). Therefore, leaving moments of ignorance named, but unexamined, obscures what is at stake when ignorance is claimed/identified/challenged. It precludes us from seeing a) its function in perpetuating the inequality that trans people experience in healthcare and b) its potential for being transformed and transformative. What this paper aims to do is to disaggregate the *knowledge gap* and examine the different kinds of ignorance that health professionals identify in their own and their peers' practices. Reading the knowledge gap through the taxonomies of ignorance this paper probes what ignorance *does for* those who claim it and what it *does to* those, about whom it is claimed. It further postulates that it is the health professionals' ethical duty to not only acknowledge their epistemic negligence but to attend to their ignorance in ways that do not education burden their trans patients. The paper concludes that one particular type of ignorance, *loving ignorance* as an epistemic practice can have transformative potential for the health professional/trans patient relationship.

## Systemic and cis-ignorance

Trans people frequently face discrimination and stigma in healthcare settings which impacts their access to and their use of healthcare (Davy, 2010; Johnson, Hill, Beach-Ferrara, Rogers, & Bradford, 2019; Pearce, 2018; Poteat, German, & Kerrigan, 2013, p. 23). A report by the UK Women and Equalities Committee found that: 'Trans people encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who *lack knowledge and understanding – and in some cases are prejudiced*' (2016, p. 3; emphasis added). These findings are echoed in literature that link disparities that trans people face in healthcare to transphobia and health professionals' lack of knowledge regarding trans health and identities (Benson, 2013; Davy, 2010; Ellis et al., 2015; McPhail et al., 2016). Trans and gender diverse people often avoid seeking healthcare due to previous negative experiences with health professionals (Lindroth, Zeluf, Mannheimer, & Deogan, 2017). Poteat et al. (2013, 26; emphasis added) note that trans patients anticipated that health professionals 'would not only be unprepared to meet their medical needs, but may also be *unprepared for their very existence*'. These examples point to structural or systemic ignorance; knowledges about trans people and health are not adequately incorporated into the existing curricula for health professionals and better medical education is needed to tackle the issue (McPhail et al., 2016).

Further, health professionals' cis-normative, essentialist and/or binary views of gender may lead to poor health practice and gatekeeping of services (Whitehead et al., 2012). In these instances, lack of knowledge becomes entangled with, and potentially reinforced by, pathologising views of trans people and transphobia producing a particular form of ignorance that I call *cis-ignorance* – a combination of ignorance and prejudice in perceptions of trans people. Whilst cis-ignorance is widespread, its instances in healthcare can be particularly harmful. Examples of healthcare-related cis-ignorance abound. For instance, Lefkowitz and Mannell (2017) UK-based study found limited understanding of trans identities among sexual health providers. Participants in the study thought that trans youth were also gay – confusing sexuality with gender identity; they also thought that trans youth had mental health issues and viewed them as mentally unstable (Lefkowitz & Mannell, 2017, pp. 11–15). Trans people also face extra burdens on their time and resources as they need to seek out health professionals who will treat them with dignity (Hoffkling, Obedin-Maliver, & Sevelius, 2017).

The impact of prejudice on the quality of care is clear and it points to the complex nature of ignorance at work in healthcare, which I argue, is more than a lack of knowledge. Rather, what emerges is a complex landscape where on a structural level systemic ignorance is intertwined with cis-ignorance and on an individual level attitudes of transphobia are folded into health professionals' epistemic practices, which negatively impact access to, and quality of, healthcare for trans people. In order to examine the different ways ignorance manifests, and its functions, I use the theoretical tool of taxonomies of ignorance grounded in feminist and critical race scholarship; it is to these I turn next.

## The many faces of ignorance

Feminist methodological interventions point to the always-entangled nature of knowledge production where epistemic practices are never neutral but are instead embedded in, and mediated through, often-unequal power relations. Feminist scholarship has long argued that the positionality of the epistemic agent is consequential in the process of knowledge production and claims to objectivity more often than not serve to obscure biases within epistemic practices (Alcoff & Potter, 2015; Code, 1988; Harding, 1993). Feminist epistemologies of ignorance throw into relief the ways in which practices of ignorance link to power and privilege. This is crucial when considering the role that predominantly cisgender medical professionals have historically played in constructing knowledge about trans identities and health; a process, in which trans people have been historically marginalized. However, as Mason argues, 'members of marginalized groups are not necessarily at an epistemic disadvantage ... social privilege does not necessarily entail epistemic privilege' and thus albeit 'membership in a socially powerful group affords certain benefits, privileged social perception is not necessarily among them' (Mason 2011, 301; see also Alcoff, 2007). Indeed, as Sandra Harding has argued, those who belong to marginalized and oppressed groups 'have fewer interests in ignorance about the social order and fewer reasons to invest in maintaining or justifying the status quo than do dominant groups' (Harding, 1991, p. 126). While cisgender health professionals have epistemic privilege, they are not necessarily better informed or better placed to understand their own complicity in making healthcare a site of where inequalities are produced and reproduced for trans people<sup>2</sup>.

Building upon critical race scholarship of Charles Mills (1997), feminist epistemological contributions provide helpful taxonomies of ignorance (see for example Alcoff, 2007; Alcoff & Potter, 2015; Tuana, 2006), offering a tool for teasing out different modes of ignorance actualized in healthcare. Mills exposes systemic distortions in the understanding of the social world by white people that emerge from structures of power and privilege. When it comes to experiences and needs of disadvantaged groups, ignorance is not a neutral occurrence or simply an absence of knowledge but an epistemic practice that is a result of 'a historically specific mode of knowing and perceiving' (Alcoff, 2007, p. 51). There is thus a need to carefully examine the origins and consequences of ignorance (Tuana, 2006, p. 15) and its resulting harms. Ignorance is closely related to and can enable epistemic violence and silencing of marginalized groups as specific power relations can make ignorance harmful; – what Dotson calls 'pernicious ignorance' (Dotson 2011, p. 239). Delay and/or denial of care in moments of ignorance on the part of health professionals are examples of how ignorance results in negative outcomes for members of a marginalized group. If we accept that in some instances, ignorance re/produces inequality, we need to understand different types of ignorance in order to work towards challenging and overcoming them.

Nancy Tuana's taxonomy of ignorance (2006, p. 4–11) offers a good starting point. Developed as a tool to think about the women's health movement, it identifies four types of 'unknowing' linked to practices of exclusion and oppression:

- (1) 'knowing that we do not know, but not caring to know'; when certain topics are deemed unworthy of attention,

- (2) not knowing that we do not know; when our current interests and beliefs effectively block knowledge of certain topics,
- (3) not knowing because socially privileged groups do not want us to know; when selected groups of people are purposefully kept ignorant,
- (4) wilful ignorance: not knowing that we do not know and not wanting to know – ‘a systemic process of self-deception that infects those in positions of privilege, an active ignoring of the oppression of others and one’s role in that exploitation’

The three types of ignorance most immediately relevant to trans health are 1, 2 and 4. However, future work in this area might shed light on the third type of unknowing, which, as Tuana notes is easier to identify in hindsight. Arguably, the fourth type needs careful handling when applied to contexts outside of the one in which it was developed, that is, to account for the links between systemic racial oppression and ignorance (Mills, 1997).<sup>3</sup> Tuana (2006, p. 10) suggests racism involves ‘an active production and preservation of ignorance’ which as Mills (1997, p. 18) highlights, enables ‘the ironic outcome that whites will in general be unable to understand the [unequal] world they themselves have made’, I argue that certain instances of ignorance on the part of health professionals closely resemble wilful ignorance, a type of unknowing that emerges when cis-ignorance – premised upon cis-normative and transphobic readings of the social world – and refusal to acknowledge health professionals’ complicity in the marginalization of trans lives and experiences collude. Like white ignorance, it is the kind of unknowing ‘to which members of dominant groups are subject by virtue of their ethically bad knowledge practices’ (Mason 2011, p. 295).

The privileged position health professionals have in the epistemic terrain of trans health can be a source of distortion. Given the historic power differential between trans people and health professionals and ongoing epistemic and testimonial injustice that trans people experience (Fricker & Jenkins, 2017), we can see how attending to moments of distortion and ignorance on the part of health professionals is key. At the same time, calling out, challenging, and overcoming ignorance becomes a social justice practice contributing to the trans rights movement. Indeed, as Fricker and Jenkins (2017, p. 270) observe, that movement ‘is not only a particularly pressing strand of social and legislative change’ but ‘also one with special relevance to questions of ignorance, for there has long been ... widespread ignorance of trans perspectives, experiences, and the shared social meanings they call for’.

Finally, not all ignorance is a form of self-serving epistemic negligence on the part of the dominant group. Tuana (2006) also discusses instances of ignorance that emerge from interests and practices not linked to injustice and inequalities, signalling the need for questioning the causes *and* consequences when scrutinizing ignorance. She identifies one more type of ignorance: *loving ignorance*, a type of ignorance premised on accepting what we cannot know, ‘a recognition that there are modalities of being that exceed our own and cannot be fully comprehended’ (p. 16). This paper builds on these insights, arguing that we need to examine what can be done not just about, but *with* ignorance and how health professionals, as epistemically privileged agents, can use ignorance to transform their practice and affect positive change, working from a place of loving ignorance.

## Methods

This paper draws on qualitative in-depth interviews with 18 health professionals based in the UK conducted as part of a larger research project on trans health, which began in January 2019. All participants were selected purposefully on the basis of their experience of having worked with young trans and gender diverse people. Participants were recruited through professional networks of the researchers working on the larger research project, as well as through social media (in particular Twitter) and snowballing. In terms of professional backgrounds, seven participants worked

as GPs, five were mental health professionals, three worked for gender identity clinics as specialists, one participant was a voice therapist, one worked as a practice nurse and one was an oncologist.

The interviews were conducted over the phone between June 2019 and February 2020 by two researchers. The interviews were semi-structured and based on a topic guide, which was allowed to change over the duration of the research to include new questions developing on the basis of ongoing analysis. The interviews lasted on average an hour and a half, allowing participants to talk about their role within trans healthcare, talk about their experiences of working with trans and gender diverse people, express their views about the current healthcare pathway and suggest improvements for the future. The interviews were audio-recorded and transcribed non-verbatim by a professional transcriber. All participants were given an opportunity to read and edit the transcript of their interview before the data were de-identified and analysed. Analysis took place in stages, beginning with initial reading of entire transcripts, followed by thematic coding and secondary coding, and finally by generation of themes. The data were coded using software (NVivo 12). The coding was undertaken independently and then checked and compared by three researchers working on the larger research project.

### Results: 'hello, i am a doctor, and i don't know much about it'

This section draws on interview data with health professionals working with trans people to identify and analyse examples of ignorance and their consequences in practice. Systemic ignorance based on the lack of formal training in trans health is the type of ignorance most easily identifiable. The awareness of this type of ignorance is commonplace, suggesting that the first type of Tuana's (2006) unknowing might be operating here – the knowing that we do not know and do not care to know; when certain topics are considered undeserving of attention and are thus not included in the medical curricula. This is best illustrated by the participants' reflections on their own training:

At the time that I went through medical school, which is some years ago now, there was nothing that I can remember at all on trans identities and healthcare for trans people (Oncologist, cis man).

Whilst I was training to become a nurse there was absolutely nothing about trans gender healthcare (Practice nurse, cis woman).

There are no training programmes [on trans health] in the UK ... When I was training to be a GP there was none. When I was doing my sexual health [training], I would see some transgender patients, but there was no specific education or training materials available (GP, cis woman).

I know that so many courses on healthcare don't even touch the necessary basics of, they don't even get to the point of saying, well, actually, you know, biological sex is a little bit more complicated than people think it is ... it's woefully inadequate and I would say that the trans healthcare in this country probably reflects that that people aren't specialising in trans healthcare. *They don't even know about trans healthcare* (Counselling professional; non-binary).

These quotes illustrate a prevailing lack of formal training and education for health professionals in matters related to trans health. The extent of this systemic ignorance becomes particularly striking in the last example, which points towards prevalence of cis-ignorance. What is signalled here is the second type of unknowing, the 'not knowing that we do not know' that Tuana (2006) identifies; whilst participants in this study spoke of lack of training, they also acknowledged that some health professionals may be entirely *unaware* of trans healthcare. The systemic ignorance is further reflected in, but also a result of, how trans healthcare is marginalized as an area of knowledge and practice. Here, again, we are entering into the 'knowing that we do not know, but not caring to know' terrain of epistemic practices, where certain issues are deemed unworthy of attention:

I wrote to NICE ... the National Institute of Clinical Excellence ... they have guidelines on everything ... I said 'Have you got any guidelines on the treatment of transgender people?', 'No we haven't and we haven't got any



plans to do in the immediate future'. Why? The equality report [referring to the 2016 The Women and Equalities Committee report] said some very damning things. Why has nothing changed? (GP, cis woman).

### *The consequences*

The variety of ways of being ignorant and health professionals' responses to these moments of self-professed ignorance suggest that whilst the lack of trans health training in formal education is a major issue, it is also just one part of the puzzle. Let us consider some examples when cis-ignorance combined with the unequal power differential produces a real burden to trans patients seeking healthcare and might lead to care being inadequate, delayed, and/or denied. This is as a pressing issue in primary care, in particular:

10% are of them [GPs] are great. The other 90% are completely clueless ... infuriatingly it's the ones who know absolutely nothing who take it upon themselves to be the gatekeepers and to ask lots of really inappropriate questions and hold back referrals ... There is a lot of GPs kind of taking it upon themselves to arbitrate whether they think somebody is trans and whether they think it was appropriate to refer them and it's often those that don't have any knowledge or understanding of the issues that are the ones that make those decisions (Practice nurse, cis woman).

[Trans] people ... just mentioned that when they had asked for a referral it hadn't been done. Whether the doctor had actually said to them, 'No, that's something that I am not doing' ... One patient said to me that they were just asked so many personal questions before the referral was made that it felt as though the doctor was deciding whether they felt the referral was appropriate or not (GP, cis woman).

Another participant also pointed out that primary health practitioners were at times unaware of existing guidelines:

[I]t would be really nice if GPs that don't know much about it would just Google the General Medical Council guidelines that are pretty clear. I tend to advise trans people to print them off when they go to their GP, because, you know, really it's like actually it's not a GP's job to make the decision about whether somebody is trans ... But again, I think the GPs think that if they refer into the [gender identity] clinic, the clinic is going to view that the person is trans, there's no due diligence and just send them through this process [of transitioning]. [So] it's a GPs responsibility to hold somebody back if they are not sure whether they are really trans or not, of course that is not how it works at all (Counselling professional, non-binary).

There are few key points raised in the quotes above. Firstly, they point at the ignorance of the *existing* processes and the trans health pathway in place. Whilst the lack of formal training in trans health remains, there are guidelines in place that primary care practitioners can and should follow. Secondly, ignorance of not only trans health in general, but also of the existing models of care becomes grounds for gatekeeping of services. Thirdly, trans patients who encounter this ignorance get burdened with the educational task, being advised to present the existing guidelines to their GPs. If we read the above outlined scenarios and the issues they reflect, through the taxonomies of ignorance discussed earlier, we can see their pernicious nature, whereby members of a socially dominant group, who hold epistemic privilege, but do not have epistemic advantage, become complicit in the oppression of a marginalized group, actively ignoring their own role in that process. Gatekeeping of services becomes a result of poor epistemic practices on the part of health professionals. What this means in practice is that trans people, who wish to be referred to specialist services, face additional challenges and potential delays in the context where their access to adequate gender affirming care is already compromised by the exceptionally long waiting times at the gender identity clinics.

Ignorance also complicates care for people already cleared for gender affirming interventions. Here, care can be denied to trans people on the basis of claimed ignorance, which is sometimes framed in the language of individual 'discomfort', 'nervousness', 'lack of confidence' around trans healthcare, as in an example below, where health professionals refuse to take on prescribing hormones to trans patients.



I think some GPs ... don't feel confident and are nervous. I can sympathize with them, but we try to upskill and provide as much support as possible ... There are some GPs who continue to refuse to prescribe for patients ... I think that's inappropriate. I think they need to undertake a level of training to be able to do that and we try to support and to signpost to that and [for them] to follow the guidance from the GMC and from other governing bodies (Specialist registrar, cis woman).

We have had divergence of opinions in our practice. Some GPs ... don't want to [prescribe hormones]. They are not comfortable with it. They are sympathetic, but they just don't want to take any risks because they are not used to it or they don't have any sort of care plans and stuff like that. My argument is that, well, you prescribe lots of other things that you don't understand, every day. So what difference does it make? There are people with arthritis who are ... prescribed ... very sort of potent drugs and other new drugs that are started by specialists, which we have very little experience of. So, to me, what is the difference? (GP, cis man).

The second example illustrates a double standard that might be operating where trans healthcare (in this instance prescribing hormones) is treated differently than other types of interventions, about which, as suggested, primary care practitioners might know equally little. To understand why ignorance is claimed in one instance and not the other, we need to look beyond the knowledge gap explanation. If we consider the fact that one in five GPs refuses to take on prescribing hormones (Barrett, 2016) even after having received specialist advice, we might be better able to grasp the function of claimed ignorance, that at times functions to mask anti-trans prejudice.

### *Who minds the gap? educational burdening*

Whilst systemic ignorance of trans health and gender affirming care is an issue, individuals have options when wanting to overcome their own ignorance. Many health professionals interviewed for this study, who were not working directly for the gender identity services, pointed to a range of ways in which they came to familiarize themselves with trans health; many sought out extra resources, read academic papers and/or national and international clinical guidelines and standards of care. Some also spoke of their patients as a source of information, as in the example below:

The process of learning for me is really from patients and sort of real life experience ... That is sort of what a lot of general practice is like where you see something, an issue that is not very prevalent or relatively rare. You sort of learn things with the patient as they go through the same journey. So it's not unusual. And that's where we pick up a lot of things as we go along (GP, cis man).

Health professionals and GPs in particular, frequently spoke about trans people as well prepared and informed patients.

Most of the consultations that I have ... people have come in ... quite well armed with information. I think that's because some people do come in prepared for a fight. They are quite defensive ... perhaps that's because of the attitudes they have got before or from what they have been told by their friends or other people that have been in the situation. If they come in very well prepared then it puts them on a slightly better footing (GP, cisgender woman).

Considering the particular power differential at play in the patient/health professional relationship, we need to attend to such moments of education burdening – where the patient takes on the role of filling in the knowledge gaps – that puts additional strain on an already marginalized group of people. Education burdening is not an uncommon experience for trans people (see for example Bauer et al., 2009; Benson, 2013). In practice, this means that to be able to access appropriate care, trans people often have no choice but to take on that burden, highlighting the epistemic negligence on the part of health professionals. An awareness of the potentially problematic nature of education burdening was rare in the interviews conducted, with an exception of a health professional working for the specialist service who openly challenged it:

Even with the best of intentions, a lot of health professionals ... take the approach of, 'Well, you know, I am curious and I am thoughtful and I want to ask the person in front of me ... I want to learn from them ...' I think sometimes people are asking individuals to fill in gaps that really should already be filled, if that makes sense.

I think sometimes that [knowledge] differential is large in a way that maybe even professionals don't see that it ... I think people are sometimes not getting exposed to that [trans health] enough and so their gap is so big they don't realise that they are having to ask the client to fill in so much of the space (Psychologist, cis woman).

The same participant also signalled how such an extra burden might lead to health inequalities as they talked about how to improve healthcare for trans people:

I think it's ... about having the system set up ... in a way that doesn't mean that trans people themselves are constantly having to go out of their way to get their needs met, because then if you are someone who might find it harder to navigate and negotiate those systems for a variety of reasons, it means there is potential for those health inequalities to emerge very quickly (Psychologist, cis woman).

This is particularly relevant when thinking about how experiences of multiple inequalities complicate access to and utilization of healthcare compounding the marginalization of trans people. Whilst education burdening of trans patients can be an epistemic practice of health professionals who are well intentioned, if we consider consequences of these moments of ignorance from which it arises, it becomes clear that it increases rather than alleviates the burdens and barriers that trans people face in healthcare. It constitutes yet another form of epistemic negligence on the part of the dominant group.

### *Loving ignorance*

This paper has so far focused on the types of ignorance and epistemic practices that are based on, and link to, practices of oppression and inequality. The last type of ignorance, however, offers hope and potential for transformation. It is based on loving ignorance as an epistemic departure point for transforming one's practice and is exemplified by moments of self-scrutiny that lead to increased effort and engagement with the community. As in the example below, of a GP who speaks of encountering their first trans patient who was struggling to find a GP willing to prescribe hormones.

That was my first experience of trying to navigate this area in terms of prescribing ... It certainly piqued my interest and made me think well ... if this patient is struggling, I wonder how many others are? And it really made me think, this isn't good enough. When I realized that there is no other option for patients ... if the GP is unable to prescribe and there is no endocrine support then actually that is the end of the road for trans people in terms of accessing hormone therapies ... I was absolutely horrified. I thought this is ... a really terrible situation and it's a dire situation, this puts people at risk ... and okay, as a GP what can I do? I can teach myself and I can navigate this for myself in terms of my own practice, but I wanted to do something more. I wanted to know whether I could make a contribution to improving access to treatment (GP, cis woman).

In the quote above we can see how, loving ignorance, an acknowledgement of one's own ignorance, of the unequal playing field and its harms and one's own privileged epistemic position in affecting change can be catalysts for transformation. Importantly, loving ignorance is the 'opposite of willful ignorance' (Tuana, 2006, p. 15), operating from a sense of humility towards difference. In the context of trans health, to be lovingly ignorant is a point of realization and departure, rather than a destination, for to be lovingly ignorant pushes one to not only acknowledge one's own dead angles, but also to actively work to overcome them in ways that support rather than burden the trans community. For the GP quoted above, this meant learning about the current processes and becoming involved in improving them also *through* getting to know their local trans community, taking the time to listen to their grievances and eventually becoming their ally and advocate. She shared:

I was asked to ... give a presentation about what are the barriers facing trans people accessing health. I thought well, I can think of some, but I am not a trans person. Maybe what I need to do is go and find some trans people and ask them. I found out about [local trans group] ... I contacted the administrator and I asked if I could come along and I explained that I am a GP, that ... I would like to ask the community about health access. I was given a really warm welcome and I went along ... and I met lots of the community. I was able to ask all of the questions that I wanted to ask ... I also realized just how much hostility there is towards doctors and I realized why. It was kind of how I started to really shape my views on what needed to be done, I guess. Actually, from that point on,

I started to attend the monthly meetings and so I went every month and I still go. I have been going now every month for about 15 months (GP, cis woman).

Going to the effort of learning from the community on its own terms and in ways that do not education burden trans people at the time when they are seeking healthcare and using that knowledge to then inform and improve practice is an example of how loving ignorance can be operationalized in healthcare. It is also a blueprint for transformation, for as Tuana (2006) notes: 'The wellspring of loving ignorance around issues of difference is not only the antithesis of arrogant ignorance, but perhaps the solution to it'; as such it offers hope. For health professionals to be able to adopt a lovingly ignorant stance towards trans health as an epistemic terrain, what they need to do is to acknowledge what it is that they do not know, and to be willing to work to overcome their own ignorance in ways that are ethical, and attend to its origins and potential consequences.

Finally, loving ignorance might come with its own set of issues, as it shifts the burden from the patient to the health professional, so from one individual to another, without offering systemic solutions. The idea is not to suggest that all health professionals should, or – given their already heavy workloads – could take on the task of attending to their ignorance in this way, but rather to offer a direction for change. Ultimately, what is needed is a type of systemic loving ignorance that would recognize individual efforts that arise from such epistemic position and build upon them to apply them systemically, attending to the gaps and omissions that exist in trans health in ways that acknowledge the power relations and the ethical consequences that follow from these.

## Concluding remarks

This paper's title is a take on the proverb that 'Ignorance is bliss'. Informed by feminist and critical race interventions, it puts that saying to work in the context of trans health, asking for whom exactly is ignorance blissful? Intuitively, the reader might suspect, that ignorance on the part of health professionals about the needs of any particular marginalized group might result in negative outcomes for this group, even more so when the health professional's own bias might mean they can be *blissfully* unaware of this group's very existence. However, and as this paper has demonstrated, simply identifying moments of ignorance and filing them away in our collective understanding as 'knowledge gaps' obscures how ignorance is not simply an absence of knowledge, but an epistemic practice in its own right. What this paper has done is to disaggregate the 'knowledge gap' and examine its multi-faceted manifestations, origins and harmful consequences. In doing so, what has become clear is that the types of ignorance that trans people encounter in healthcare are varied. At times, systemic ignorance and cis-ignorance get folded into practices of wilful ignorance, a type of unknowing that refuses to acknowledge health professionals complicity in the ongoing marginalization of trans people. Given the key role that health professionals play in enabling or gatekeeping access to gender affirming care, for those trans people who seek them, it is clear that such instances of ignorance can lead to denial and/or delay of care, compounding the barriers that trans people face in healthcare. In other instances, more benevolent forms of ignorance, result in negligent epistemic practices and education burdening of trans people, who are tasked with filling in the gaps in health professionals' knowledges of trans possibilities, identities and health. Yet, for health professionals committed to trans-equality and to meeting the needs of their patients, ignorance can also lead to exploration of one's own dead angles in a way that does not shift the weight of the task back onto the trans people in their care. Here, awareness of one's own professions' complicity in the marginalization of trans people, engagement with the local trans community, openness to learning from it in ways that does not further tax it, but rather support it, can make loving ignorance a basis for redefinition of the patient/health professional relationship. Ignorance of one's own ignorance might be blissful for those health professionals whose lives are marked by cisgender and epistemic privilege. However, it is only through collectively and individually facing ignorance in its many manifestations, acknowledging what consequences it has for trans people, and taking on the task

to transform it, that health professionals might start to undo and prevent its harms. Starting from a place of loving ignorance might offer a way forward.

## Notes

1. I use the term trans as an umbrella term that brings together a range of identities and experiences; such broad scope of trans possibilities can contrast with more rigid forms of categorization employed by the health professionals who assess trans people for gender dysphoria at the gender clinic (Pearce, 2018, p. 6).
2. 'Cisgender' denotes identity of people who identify with the gender that they were assigned at birth.
3. Whilst parallels can be drawn between transphobia and racism, it is important to acknowledge how the two intertwine, reinforce and collude with each other and other forms of injustice, such as class inequalities causing continuous marginalization of trans people of colour (Gehi & Arkles, 2007; Raha, 2017).

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