Published in final edited form as:
J Health Care Poor Underserved. 2018 ; 29(4): 1300–1318. doi:10.1353/hpu.2018.0097.

Transgender and Genderqueer Individuals' Experiences with Health Care Providers: What's Working, What's Not, and Where Do We Go from Here?

Aleta Baldwin, PhD, MPH,
University of Texas at San Antonio.

Brian Dodge, PhD,
Indiana University, Bloomington.

Vanessa R. Schick, PhD,
Brenda Light, MS,
University of Texas at Austin.

Phillip W. Schnarrs, PhD,
University of Texas at Austin.

Debby Herbenick, PhD, MPH,
Indiana University, Bloomington.

J. Dennis Fortenberry, MD, MS
The Indiana University School of Medicine.

Abstract

Research demonstrates health disparities between gender-minority individuals and cisgender individuals. These disparities arise from multiple sources, including negative health care experiences. This study examines interactions between transgender and gender non-binary (TGGNB) individuals and their health care providers. We analyzed 119 participants' descriptions of positive and negative health care experiences, and what they wish providers knew about caring for TGGNB patients. Health care experiences went well when providers and staff used inclusive language, demonstrated their experience and education, and treated identity disclosure as routine. Negative interactions were characterized by misgendering, unfamiliarity with TGGNB people and health issues, and transphobic practices. Participants wished providers understood their health concerns, did not expect their patients to educate them, and created a welcoming clinical environment. Medical educators, administrators, and providers share responsibility for improving TGGNB patient experiences. Through a framework of cultural safety, we recommend several changes to ensure more equitable treatment in health care.

Please address all correspondence to Aleta Baldwin, PhD, MPH, MB 3.412, One UTSA Circle, San Antonio TX 78240; Phone: (209) 458–5732; aleta.baldwin@utsa.edu.

Keywords

Patient-provider communication; transgender; gender non-binary; LGBTQ health disparities; health care experiences; cultural safety

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Transgender (trans) and gender non-binary individuals (TGGNB) are among the most stigmatized individuals in the U.S.[1,2] The term TGGNB is used to refer to individuals who express their gender in ways that differ from the established cultural norms linking gender to sex assigned at birth. The term TGGNB includes people who identify as transgender men, transgender women, as well as genderqueer and gender-diverse, among others. The social marginalization of TGGNB individuals has a significant impact on their health and quality of life.[3] Compared with the general population, TGGNB people experience significantly higher rates of poor physical and mental health, HIV/STI infection, drug and alcohol use, non-suicidal self-harm, and suicidality.[4,5] Transgender and gender non-binary individuals (TGGNB) are also disproportionately more likely to experience homelessness, extreme poverty, underemployment, and lack health insurance,[5] each of which adds a barrier to accessing health care.

When TGGNB individuals do have access to health care, they frequently experience discrimination and stigma from within the health care system.[6] Recent findings from the United States Transgender Survey show that one-third of TGGNB individuals have experienced a negative interaction with a health care provider related to their gender.[7] Discrimination, both experienced and anticipated, discourages TGGNB people from seeking future care.[8–10] In one study, as many as one in three TGGNB individuals reported foregoing or delaying medical care due to anticipated discrimination.[11] Lack of care-seeking due to fear of discrimination negatively affects the mental and physical health of TGGNB individuals, including worse general health and greater odds of negative mental health outcomes, such as depression.[12] Furthermore, many TGGNB individuals face an additional barrier to care in locating providers who can and will provide them care, as TGGNB individuals are frequently refused care by providers.[5,13]

The burden of unmet health care needs of many TNGGB individuals makes barriers faced from within the health care system particularly pernicious. Transgender and gender non-binary people may require gender-affirming interventions such as hormone therapy or surgical procedures that make their authentic gender expression dependent upon the medical system.[14] Thus, those who face discrimination because of a transgender or non-binary gender presentation, and seek to lessen experienced discrimination through medical intervention, subject themselves to potential discrimination from those tasked with providing medical care.

In addition to discrimination and refusal of care, negative interactions that TGGNB individuals report also include having to teach their providers about lesbian, gay, bisexual, transgender and queer (LGBTQ) health care.[11] Lack of provider education about LGBTQ health is a known barrier to care for TGGNB individuals.[15] One-third of medical schools in the U.S. require no hours of LGBT-related content for students during their clinical training years.[16] As a result, many health care providers themselves report being ill-equipped to provide care to TGGNB patients.[10] Given this deficit in formal medical curricula, health care providers often learn about gender-affirming care, and how to provide it, through self-guided study. Gender-affirming health care recognizes and affirms TGGNB patients' gender identities and expressions.[17] As laid out in the World Professional Association for Transgender Health's (WPATH) Standard of Care, it involves a range of behaviors in addition to specific medical interventions, from using a patients' preferred name and pronouns to asking a patient permission before touching them.[18]

Most of the research on health care experiences among TGGNB individuals is limited to samples of binary transgender men and transgender women (see Chisolm-Straker et al., 2017; Kosenko et al., 2013; Seelman et al., 2017; and Wagner and Asbury, 2016 for exceptions).[12,19–21] However, gender non-binary individuals who reject binary gender identification, for example genderqueer individuals, also face stigma for violating social rules of gender, yet are underrepresented in the literature. For example, Miller and Grollman found that individuals who were more gender nonconforming experienced higher rates of everyday and major discrimination than individuals who were less gender nonconforming (i.e., who adhered more closely to traditional gender roles/norms).[3] We know little about how gender expression along a spectrum shapes these individuals' health care experiences. Additionally, the research on TGGNB individuals' health care experiences identifies a variety of characteristics of negative or discriminatory interactions, but far less work investigates positive patient-provider interactions (see Ross et al.[22] for an exception).

Study purpose.

In this study, we examine the experiences of a unique sample of TGGNB individuals, including a large proportion of individuals who identify as genderqueer, and adopt a strengths-based approach[22] to understanding their health care experiences by exploring characteristics of positive, as well as negative, health care interactions. Further, we offer strategies for enhancing TGGNB patient care informed by our results and the framework of cultural safety. The concept of cultural safety originated from health care providers' attempts to address the entrenched health issues faced by the Maori of New Zealand.[23] Cultural safety suggests that to improve the health of minority populations we must address the role of institutions and social structures in perpetuating health disparities and, further, tasks both providers and institutions with addressing the social inequity that is reproduced within health care.[24–26]

Methods

Study design.

This paper presents primary analyses of data drawn from an online survey of LGBTQ identified individuals residing in the United States. The LGBTQ Health care Experiences Study utilized a concurrent nested (or, within-stage mixed-model) design in which qualitative and quantitative data were collected at the same stage with the same instrument.[27] Previous similar studies have effectively utilized online surveys with open and closed-ended items for data collection and analyzed these data as qualitative.[19,28] For the present research, we limited our analyses to qualitative exploration of participant responses to a set of open-ended items. The survey, which we developed specifically for this study, was conducted using Qualtrics and was available online for six weeks. This survey included up to 65 individual items related to the following areas: socio-demographics; general and sexual health; gender and sexual identity; health care access and use; and experiences and interactions with clinicians. Open-ended items appeared to participants in large text boxes to encourage participants to write as much as they liked and no character limit was set for these responses.

Recruitment.

The size of the TGGNB adult population in the U.S. is now estimated in the range of 0.65%, or 1.4 million adults, making population-representative data almost non-existent.[29] Given the relative size of the population, our study used a non-probability sampling technique. In order to be eligible to participate, individuals needed to meet each of the following criteria: 1) be 18 years of age or older, 2) reside in the U.S., and 3) identify as transgender or gender non-binary *or* as a lesbian, bisexual, pansexual, or queer woman. Thus, individuals from across the gender spectrum were eligible for this study. However, for the present study, analyses were conducted on a restricted sample of TGGNB participants. Cisgender women (i.e., those assigned female sex at birth and who identify as women) were excluded from the present study because of unique differences between gender and sexual identity-related interactions with providers, the results of which are published elsewhere.[30] Recruitment messages were posted to multiple websites, listservs, and social networking sites (e.g., Twitter and Facebook). Organizations focused on LGBTQ health were targeted for disseminating recruitment messages. In the sample for the present study, individuals from 32 states in all regions of the country were represented.

Recruitment messages included a brief description of the study (i.e., an anonymous survey on the health care experiences of LGBTQ individuals) and a link to the eligibility screener. Participants who met the eligibility requirements and consented to participate were directed into the survey. The survey took approximately 30 minutes to complete (M=28.4, SD=16.5). Upon completion of the survey, participants interested in entering a drawing with a 1 in 15 chance of winning a $25.00 electronic gift card could provide an email address in a separate online database. Study protocols were reviewed and approved by the institutional review board at the academic institution of the first author at the time of data collection. Data were collected during the spring of 2015.

Measures.

We gathered sociodemographic data through questions about participants' age, race and ethnicity, gender identity and presentation, and sexual orientation. Participants were asked a series of open-ended questions regarding interactions with their health care providers that occurred post identity-disclosure. For this study, we analyzed responses to these three questions. One question asked participants to tell about a time when gender identity disclosure to a provider went well; another asked about a time when it went poorly. A third question asked participants what they want their providers to know about caring for TGGNB patients.

Analysis.

Demographic characteristics, reported using descriptive statistics, were conducted in SPSS (Version 24).[31] Participant responses were analyzed following the principles of semantic, social constructionist, thematic analysis. Thematic analysis is particularly useful for identifying patterns and themes across participant narratives. We used the process of thematic analysis described by Braun and Clarke as our guide.[32] Following careful review of the data, the primary coder generated initial codes and created a coding schema for each of the three sets of participant responses. These codes were determined inductively from line-by-line review of the data. Two coders independently coded the data and then met to discuss any differences in coding until consensus was reached. The coders discussed relationships between codes and began to develop the analytic themes by organizing and refining the initial codes. We then reviewed, refined, and subsequently defined the themes for presentation. Table 1 presents themes and subthemes.

Results

Socio-demographic characteristics.

In all, 119 participants met the study inclusion criteria and provided analyzable responses. We excluded 18 participants who answered N/A or similarly to each of the three questions. Table 2 presents the sociodemographic characteristics of the sample. The mean age of participants was 32 years (age range: 19–62). Most participants identified as genderqueer (63.0%, n=75). Transgender men constituted 23.5% of the sample (n=28), while 13.4% of the sample were transgender women (n=16). The majority of the participants were White (n=90, 80.4%) with at least an undergraduate degree (n=86, 72.0%). Most participants (n=63, 52.9%) identified their sexual orientation as queer, and 28.0% (n=33) described their gender presentation as somewhat masculine/butch.

Characteristics of positive clinician-patient interactions.

Using language that respects gender diversity.—Participant descriptions of positive interactions were characterized by the staff ‘s and providers’ use of language that demonstrated respect for diverse gender identities. Primarily, this was reflected in the correct use of pronouns and names. For example, one participant described an intake experience in the emergency room, in which “the nurses were very respectful of my name and pronouns despite neither being changed/corrected officially which [. . .] I explained to them and they easily accepted” (Transgender woman, 29 years old). Participants also described positive interactions that included use of gender-neutral language to refer to sexual and relationship partners, anatomy, and procedures:

> I disclosed at an urgent care/emergency facility that I did not have time to research ahead of time. I had no idea if they were trans* aware or trans* friendly [and] I would eventually have to disclose if I wanted to get any help for the pelvic pain/bleeding problem I was having. All of the staff [. . .] from start to finish used respectful language when discussing my body and the process during the *pelvic exam*. No feminizing language was used at all [. . .] I was treated respectfully

> not just by the doctor but the nursing staff and all the folks in the reception area. (Transgender man, 35 years old)

Knowledgeable and experienced with TGGNB health.—Positive interactions with providers were also characterized by the provider demonstrating their experience in treating TGGNB patients. For example, one participant described a particularly fraught health care appointment during which the provider's knowledge and experience with TGGNB patients put them at ease:

> I was referred to get an ultrasound to check my ovaries by my endocrinologist. It was the first invasive exam I had ever had so I was pretty anxious and nervous, and I was planning on explaining everything to the doctor. But she was totally cool and let me put the wand in myself and let the gown cover everything so I didn't have to expose myself. (Transgender man, 22 years old).

Another way providers facilitated positive experiences in providing care to TGGNB patients was in offering to manage aspects of transition-related care, or by offering strategies for navigating the health care system. In one instance of this, a participant described a provider who was: "affirming and asked questions about what I'd like to get out of hormone treatments, we discussed strategies for hormone treatment that take my non-binary gender into consideration [for instance] the implications of starting/stopping hormones" (Genderqueer person, 29 years old). Similarly described by participants were providers who were explicit about the limits of their knowledge and experience, thus allowing patients to adjust their expectations. One participant described such a provider, who "was transparent and explained that they did not have a lot of knowledge about GQ/trans people. They assured me that they would ask open-ended questions, do research, and consult with other doctors" (Genderqueer person, 30 years old).

Treating identity disclosure as routine.—Whether participants disclosed their gender identities on intake forms, or through questions about gender identity, providers who treated the identity disclosure as routine were well-received by participants. Several participants described gender identity disclosure as a response to an indirect question, for example a question about last menstrual period, or about sexual activity or partners. One example comes from a participant who disclosed to an indirect question, saying, "When asked when I had my last period, I told the nurse that I do not get a period because I am transgender. She simply entered that information into the computer in the place of a date" (Transgender woman, 27 years old). Another participant described a time when she disclosed to a provider who "understood what it was and said there would be no problem. Asked about pronouns and preferred names in case [they] differed from the legal name on forms and in the system, and the world moved on" (Transgender woman, 25 years old). When providers understood the identity disclosure and responded neutrally to the information, participants felt the interaction went well.

Characteristics of negative clinician-patient interactions.

Misgendering.—One of the most common negative interactions was being misgendered. Misgendering occurs when a person is assumed to be of a gender with which they do not identify. For example:

> [The student provider] reacted strongly with surprise when I shared that I identified as genderqueer, that I was taking hormones, and that I had not undergone and did not plan to undergo any surgeries. The practitioner then repeatedly misgendered me [through incorrect pronouns] to her supervising clinician while in the room with me (Genderqueer person, 26 years old).

Another participant noted that only after disclosing their identity did the provider begin to misgender them, saying, “I was at an orthopedist, and outed myself when they asked why I was on testosterone. They then started messing up pronouns” (Genderqueer person, 27 years old).

Lack of information and experience.—A key feature of interactions that went poorly was a provider who either lacked knowledge of the health care needs of TGGNB individuals or lacked experience treating TGGNB patients. For example, one participant described an interaction during a pelvic exam noting he was “laying on my back and my legs were in stirrups” when the provider said they had “never treated a transgender patient before, that I was extremely brave” (Transgender man, 25 years old). While the provider may have intended to pay a compliment to their patient, from our participant’s perspective, they were exotified while in an incredibly vulnerable state.

Another way that providers’ lack of education or experience yielded negative interactions had to do with the curiosity demonstrated by irrelevant, and often pathologizing, questions. For example, one participant described an experience during which they were misgendered as well as subjected to inappropriate questions: “[The provider] refused to use the correct pronoun and asked intrusive and irrelevant questions about my childhood to determine why I was trans*, ignoring the reason I sought treatment” (Genderqueer person, 40 years old).

Transphobia.—Transphobia constitutes a final theme summarizing negative provider-patient interactions. This theme encompasses instances of providers who were visibly uncomfortable after participants disclosed TGGNB identity or pathologized TGGNB identity. For example, one participant described a provider who said the patient was “confused” and “had a disorder” (Genderqueer person, 30 years old).

A common experience described within this theme was the denial of care related to patients’ TGGNB identity. Participants described three distinct ways in which they experienced denial of care. First, participants reported denial of care related to transition. For example, one participant described a provider who refused to discuss hormone replacement therapy “due to religious beliefs” (Genderqueer person, 30 years old). Denial of care was also experienced because of the participant’s gender identity. For example, one participant described a provider who

> refused to do a Pap on me because I'm trans/genderqueer. She acted like she didn't want to touch me. She also wouldn't discuss sexual health with me, even when I brought it up directly—she said she assumed I didn't have sex (Genderqueer person, 35 years old).

Finally, participants noted that being referred to another provider is itself a kind of denial of care. It may be done with good intention, for example if a provider does not feel they can adequately provide the necessary care, but it leaves patients with the impression that they were refused medical care and often results in the same outcomes: delayed care, or no care at all. In the words of one participant: "The idea that it takes specialized knowledge to work with me or other trans people is frustrating and inaccurate" (Genderqueer person, 25 years old).

What providers should know.

Our final question concerned participants' advice to providers in caring for TGGNB patients. Two themes organized these data.

Trans 101.—Concerning education, participants wanted health care providers to have what one participant referred to as "trans 101,"—essential, basic information about gender identity, sex, and the major health concerns faced by TGGNB. Other participants echoed this, saying providers "should know the basics regarding our unique circumstances and health needs. They should understand hormone therapy *and* how we see our bodies" (Genderqueer person, 34 years old). Further, participants felt that medical students should not just receive education and training on TGGNB health care, but that the training specifically should involve TGGNB people themselves. Simply stated, provider training on trans health and patient care should involve consulting with "actual trans people" (Transgender woman, 28 years old).

Included in the trans 101 theme, participants reported that it is important for providers to recognize that not all health issues are related to being TGGNB. In the words of one participant: "Realize that while being LGBTQIA has a large effect on people's lives, we can have problems that are not related to this" (Transgender man, 25 years old). Similarly, participants wanted providers to know the multiple possibilities for gender identity and expression, and that not everyone who is TGGNB wants hormones or surgeries: "Don't assume that everyone who is trans wants to medically transition, but always be willing to have that discussion and see where they are" (Genderqueer person, 22 years old).

Participants also noted they should not be responsible for educating providers, and that it is providers' responsibility to seek education on, for example: "the most up-to-date recommendations for transgender-related health care, [. . .] how to communicate with patients and create a more inclusive and safe interaction, as well as trans specific health care recommendations" (Transgender man, 32 years old). Specifically, participants felt that providers should not rely on patients to teach them about providing care to TGGNB people, which they conceptualized as undue burden: "Don't put the burden on your patients. You would never require any of your other patients to educate you" (Genderqueer person, 30 years old). Participants also felt that providers should ensure others in their practice are educated about TGGNB health as well, and many participants cited specific resources they wanted providers to be familiar with, including the WPATH Standards of Care18 and conferences such as the Gender Odyssey Conference, which includes a track for health care professionals that offers continuing education credits.[33]

Trans 101 also included comprehensive sexual health information, which is, necessarily, inclusive of TGGNB individuals. Participants noted that providers rarely talk with them about sexual health concerns such as sexual or domestic violence because they may be uncomfortable, lack information, or think the issues are not of concern TGGNB individuals. For example, “Don’t assume that LGBTQ folks cannot experience sexual assault or intimate partner violence [providers should] screen for these things in an inclusive manner” (Genderqueer person, 40 years old). Participants wished providers would avoid assumptions about sexual partners and talk to them about sexual health issues as they would with any other patient. However, providers are often reluctant to address domestic violence in general.[34] As such, this may be a way in which the TGGNB community experiences care in similar ways to other patient groups.

Inclusive care.—A second theme around advice for providers concerns the questions they ask during medical visits. Participants wanted providers to ask only medically or psychologically relevant questions. Thus, when it comes to providers’ curiosity around TGGNB identity or experiences, one participant advised: “If you have a question about transgender people or my life experience irrelevant to my care, please ask first whether I am receptive to it. Sometimes I am OK with providing education, but I may not always be” (Transgender man, 46 years old). This theme also includes participants’ desire for providers to reserve judgment and be aware of personal biases: Providers should “maintain a non-judgmental curiosity” (Transgender man, 34 years old) and leave biases “at the door” (Genderqueer person, 42 years old).

Inclusive care also involves creating a friendly clinical environment through changing forms and intake procedures to be more welcoming of gender diverse patients. In the words of one participant:

> I understand why health care providers need to know about the health of my vagina, but as a trans man, I don’t like being given a form that says, “For women” on the top in order for them to get the info they need. It’s discouraging and already sets up the atmosphere of not being trans friendly or trans sensitive affirming and respecting my gender identity is important, especially using proper pronouns (Transgender man, 28 years old).

Other participants suggested paying careful attention to gendered language beyond pronoun use for example “using parent instead of mother and father” (Transgender man, 51 years old).

Finally, the theme of inclusive care also concerns the treatment options available to TGGNB patients. Specifically, participants wished providers would care for them, when possible, rather than refer them out. For example, one participant advised providers to “learn to prescribe hormones and learn about pre- and post-surgery care for clients who choose surgery" (Transgender man, 35 years old). Participants also addressed medical gatekeeping by providers. One participant, for example, felt that it was not the provider's job to "decide whether trans people need or deserve specific health care or procedure" because:

> Hormone replacement therapy, gynoplasty, facial feminization surgery, mammoplasty, are not cosmetic procedures. They are medicine. They save lives. If a person requests medical transition, it is because they are already experiencing harm, and these are the things that can alleviate it (Genderqueer person, 24 years old).

Discussion

Our study contributes to a growing body of literature exploring TGGNB people's experiences in health care.[6,12,19–21,29] While a few of the existing studies used samples that include genderqueer individuals, our sample is unique in that the majority of our participants identify as genderqueer, a group of people rarely represented in the literature. Existing research findings and subsequent recommendations for providers may not be as representative of those whose gender expression challenges the gender binary in this way.[3] For example, that providers should not assume medical transition is a goal for all TGGNB individuals.

Secondly, while we collected data on negative provider-patient interactions related to gender identity, we also described characteristics of positive interactions. To our knowledge, only one other study has collected data on positive health care experiences for TGGNB people or asked TGGNB people what they wish their providers knew.[22] This approach allowed us to identify features of patient experiences that can be adopted by providers and larger medical systems to ensure better care for TGGNB patients.

In each of three sets of responses (positive interactions, negative interactions, and advice to providers), language features heavily. In keeping with previous research,[10,19] this study found that the use or misuse of specific pronouns, preferred names, and gender-neutral terminology often defines positive and negative experiences. Unsurprisingly, participants wished providers knew basic terminology around gender, sex and sexuality terms. Similar to Ross and Castle Bell, we found that language used on intake forms and by office staff, beyond pronouns and correct names, creates the welcoming clinical environment.[35]

Beyond basic terminology, providers' knowledge and previous experience helped determine a positive or negative interaction. In our study, as in others, participants reported educating providers about basic transgender identity issues and health information.[5,36] Many participants resented the need to educate practitioners.[19,21] This is not free of consequence, as having to educate providers is associated with perceived discrimination and delayed health care.[11,37] In keeping with previous research,[3] our participants also experienced invasive and irrelevant questions, including questions that frame gender identity as a pathology. Along with the denial of care, which is also reported in the literature,[5,20,37,38] these are key features of negative interactions.

A cultural safety approach.

In addition to training providers in gender-affirming care, our findings suggest the necessity of implementing institutional and system-level changes to support providers in their abilities to provide such care to TGGNB patients. As such, we recommend the framework of *cultural safety,* which places the shared responsibility of the provision of quality care on providers, the systems they work in, and the larger institutions of medicine, through which to approach these changes.[23,24] Below, we discuss how the cultural safety approach can facilitate improved patient care experiences for TGGNB.

Culturally safe TGGNB patient care and medical education.—In the absence of formal training on TGGNB health care, many providers are taught by their TGGNB patients. However, in such interactions, the traditional role of medical authority is challenged, and may lead to hostility on the part of the provider.[10] Lack of provider education therefore compromises the clinicians' ability to provide care and contributes to interactions that keep TGGNB from returning to care. When our participants described interactions that went well, they described providers who came into the interaction with knowledge and experience. Programs responsible for educating medical professionals should prioritize such knowledge and experience in the formal curricula. The Association of American Medical Colleges, notably, created a resource for medical educators that contains curricula aimed at improving health care specifically for TGGNB individuals.[16]

Our participants further expressed the need for medical providers to have training that involves—rather than is just about—TGGNB patient care. Existing research points to the utility of that strategy, as studies have found that not having personal experience with TGGNB people is related to anti-trans attitudes,[40] whereas providers with "a personal connection" to TGGNB individuals were more likely to resist stigma/discrimination in their interactions with TGGNB patients.[10] Further, medical students who have experience with TGGNB people have more positive attitudes, more knowledge, and conduct more comprehensive sexual history-taking, than peers who do not.[41] In multiple studies, health care providers have identified lack of medical knowledge on TGGNB individuals as a barrier to the provision of such care.[42–44] Lack of education for providers is perhaps best conceptualized as a systemic issue, a reflection of the power differential between cisgender and TGGNB individuals that exists in our society—a bug of medical training, rather than a failing on the side of providers. A culturally safe approach, in recognizing the expertise TGGNB individuals have and prioritizing reciprocity in learning by involving TGGNB individuals in curriculum design and as educators, may help improve providers' future interactions with their TGGNB patients.

Our participants also noted the critical role that medical staff and the clinical environment play in facilitating positive or negative interactions. Thus, we agree with Stroumsa et al., that while educating physicians is important, information on providing care to TGGNB patients must also be directed at physician assistants, nurses, medical assistants, emergency care workers, and administrative staff.[14] The experiences and advice of our participants supports this as well. As medical providers alone do not bear the responsibly for ensuring TGGNB patients receive respectful care, solutions to improving TGGNB patient care cannot only involve provider education. Indeed, much of the patient's experiences with providers included factors that were external to the patient-provider interaction. We agree with Redfern and Sinclair that much can be improved for TGGNB patients with small changes in protocol, the office environment, and intake forms.[45] Due to a variety of financial and institutional barriers, many TGGNB people may not have formally changed their legal names to their preferred names or may not have their preferred names appear on their insurance and medical documentation. Protocol modifications including standardizing the collection and use of a preferred name is one of the first and easiest steps health care systems can make and it aligns with the culturally safe practice of addressing social inequity.

Wagner and Asbury found that within health care visits, transgender individuals discuss their gender identity upon it being "immediately salient" and not just relevant.[21] Given previous and expected discrimination from providers, this strategy for avoiding discrimination makes sense. However, were patients more frequently to encounter knowledgeable and experienced providers, it would likely eliminate the need for such strategies. Thus, we agree with Dunne et al. that collecting gender and sex information should be a routine part of the health care visit, and broader gender options should be made available for patients to choose.[46] It must, though, be noted that many TGGNB patients receive health care in situations where it is not necessary, or even safe, to disclose identity. Finally, it is also necessary to address the wider social environment in which TGGNB individuals seek and receive care in order to see the necessary improvements in health disparities. Previous studies have found that structural discrimination, not simply interpersonal discrimination, leads to negative health care outcomes.[47,48] These data support Wagner and Asbury's argument that the medical community must take steps to address the social discrimination faced by those who are TGGNB.[21]

Thus, as applied to caring for TGGNB patients, cultural safety involves recognizing both the social marginalization and the cultural expertise of TGGNB people, creating—with the input of TGGNB people—and practicing standards that are cognizant of gender diversity and responsive to patients' gender identities, and actively monitoring for unintended biases and micro-aggressions by providers and staff.[26] For health care systems and medical institutions, it involves changing information and data collection systems, providing gender neutral and inclusive spaces within institutions, and educators who model and promote acceptance of gender diversity.[49]

Limitations.

Our findings should be considered alongside the limitations of the study. First, our participants were recruited using a non-probability recruitment strategy. An online recruitment approach was useful in allowing us to access a relatively hidden population.[50] However, future research would benefit from exploring strategies for recruiting and engaging TGGNB individuals, and other groups of sexual and gender-minority individuals, using a wide range of sampling methods to determine which may be most effective. While some researchers perhaps have not included TGGNB and other non-binary identities in previous studies due to the assumption that the numbers of people who would report these identities is too low, it may also be the case that we simply have not afforded individuals the option to report such identities consistently in prior research.[51] Still, our sample is limited by racial and ethnic homogeneity, as well as with access to resources (as all of our participants had Internet access). A more diverse sample would likely have led to different findings. Finally, given the retrospective nature of our instrument, participant responses may be subject to recall bias.

Conclusion.

Our results support prioritizing the provision of care for TGGNB in formal medical education and training programs to ensure that health care providers and their staff have the knowledge and experience they need to provide higher-quality care to gender diverse patients. Our results further support adjusting patient intake protocol and forms at the system-level to incorporate gender-neutral terminology and facilitate the use of preferred names and pronouns. As non-discrimination policies are reversed at the federal level,[52] and policies that explicitly codify discrimination against transgender individuals are introduced and debated,[53] ensuring that medicine is a place where TGGNB people can expect to be safe and respected is of the utmost importance, especially given the relationships among discrimination, discrimination within health care, and the health of minority populations.

Acknowledgments

The authors would like to thank Stephanie A. Sanders.

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Table 1.

CODING SCHEMA

Theme	Subthemes
What's Working	
Language use (Respectful of gender diversity)	
Correct names, pronouns	Staff and clinic environment
Terminology isn't gendered Sexual diversity acknowledged	
Knowledge and experience (Demonstrates)	
Through exams and procedures Can manage transition-related care	Help navigate health care systems
Acknowledges lack of experience	
Treating identity disclosure is routine	
Affirming or neutral reaction	
What's Not Working	
Language use (Misgendering)	
Non-inclusive patient forms Incorrect names or pronouns	Not consulting patient information Refusing to use Mistaken
Knowledge and experience (Lacks)	
Trans curiosity	Exoticizing Asking irrelevant questions
Inaccurate medical info	
Transphobia	
Pathologizing gender difference	
Displays discomfort Denies care	Transition-related care
	Denies care because of patient's gender Refers out rather than treat
What Providers Should Know	
Trans 101	
Education includes gender and sexual diversity	Comprehensive sexual health Includes trans people as experts
Not a monolith	Not all issues are related to being TGGNB Not all TGGNB people want hormones or Surgery
Don't make us teach you	Educate yourself and others
Inclusive care	
Asking questions thoughtfully Checking bias, assumptions, judgement at the door Patient forms, clinical environment, provider and staff language	
Providing transition-related care	No medical gatekeeping

Table 2.

PARTICIPANTS’ DEMOGRAPHIC CHARACTERISTICS

	Genderqueer		Transmen		Transwomen		Total	
Characteristics	**n = 75**	**(%)**	**n = 28**	**(%)**	**n = 16**	**(%)**	**N = 119**	**(%)**
Age								
18–24	12	(16.0)	8	(28.6)	2	(12.5)	22	(18.5)
25–29	21	(28.0)	8	(28.6)	6	(37.5)	35	(29.4)
30–39	29	(38.7)	7	(25.0)	4	(25.0)	40	(33.6)
40–49	10	(13.3)	4	(14.3)	1	(6.3)	15	(12.6)
50+	3	(4.0)	1	(3.6)	3	(18.8)	7	(5.9)
Race/ethnicity								
White	57	(80.3)	19	(76.0)	14	(87.5)	90	(80.4)
Hispanic Origin	3	(4.2)	3	(12.0)	1	(6.3)	7	(6.3)
Asian	5	(7.0)	1	(4.0)	1	(6.3)	7	(6.3)
Black	3	(4.2)	—	—	—	—	3	(2.7)
Multiracial	3	(4.2)	2	(8.0)	—	—	5	(4.5)
Education								
High school or GED	2	(2.7)	1	(3.6)	2	(12.5)	5	(4.2)
Some college or Associates	16	(21.3)	4	(14.3)	8	(50.0)	28	(23.5)
Bachelor’s	27	(36.0)	12	(42.9)	4	(25.0)	43	(36.1)
Graduate (Master’s or Doctoral)	30	(40.0)	11	(39.3)	2	(12.5)	43	(36.1)
Sexual Orientation								
Queer	43	(57.3)	17	(60.7)	3	(18.8)	63	(52.9)
Pansexual	17	(22.7)	3	(10.7)	4	(25.0)	24	(20.2)
Lesbian or Gay	6	(8.0)	3	(10.7)	5	(31.3)	14	(11.8)
Bisexual	3	(4.0)	3	(10.7)	4	(25.0)	10	(8.4)
Unsure /Questioning	1	(1.3)	2	(7.1)	—	—	3	(2.5)
Straight/Heterosexual	2	(2.7)	—	—	—	—	2	(1.7)
Asexual	2	(2.7)	—	—	—	—	2	(1.7)
Other	1	(1.3)	—	—	—	—	1	(0.8)
Gender Presentation								
Very feminine/femme	4	(5.4)	—	—	2	(12.5)	6	(5.1)
Somewhat feminine/femme	4	(5.4)	—	—	11	(68.8)	15	(12.7)
Slightly feminine/femme	12	(16.2)	—	—	1	(6.3)	13	(11.0)
Androgynous	14	(18.9)	1	(3.6)	1	(6.3)	16	(13.6)
Slightly masculine/butch	16	(21.6)	3	(10.7)	—	—	19	(16.1)
Somewhat masculine/butch	19	(25.7)	13	(46.4)	1	(6.3)	33	(28.0)
Very masculine/butch	5	(6.8)	11	(39.3)	—	—	16	(13.6)