

Experiences of trans patients in primary care settings: findings from The OutLook Study

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ABSTRACT

Background. Relationships between primary care providers (PCP) and trans patients remain important, necessitating discussions about gender identity, health and their intersections. **Methods.** Using an online survey, we explored socio-demographic and psycho-social factors associated with: (1) disclosing gender identity; (2) discussing gender identity-related health issues; and (3) comfort sharing gender identity with PCPs, among trans people ($n = 112$) over 16 years of age, sampled in Waterloo, Ontario, Canada. Bivariate and multivariate methods using modified Poisson regression generated effect estimates. **Results.** Age, birth presumed gender, employment status, family support, and transphobia were significantly associated with disclosing gender identity, discussing gender identity-related health issues, and comfortability sharing gender identity with PCPs. **Conclusion.** Increasing PCPs' knowledge of trans-related health issues is stressed to improve access and quality for trans patients.

Keywords: community-based research, gender identity, healthcare access, medical education, minority stress, primary care, trans health, transphobia.

Introduction

Trans people experience differential health outcomes and care access compared to cisgender persons.¹ Stigma precluding resource access contributes to adverse health outcomes such as diabetes, hypertension and depression among trans people.¹ Despite these, trans individuals face barriers to care that result in under-utilisation and/or avoidance of health care services.^{2–4} For example, a recent study identified single relationship status, under-housing and a transfeminine Indigenous and/or person of colour identity as factors independently associated with not having a family physician.⁵

This inequity necessitates community-specific and relevant health care, but many trans people receive suboptimal treatment in healthcare settings.¹ Although trans individuals positively evaluate health care availability in Ontario, they rate the quality of care in their community as poor.⁶ Despite providers' potential to alleviate negative experiences trans people face, practitioners and trans patients alike report feelings of discomfort during medical encounters. Practitioners feel insufficiently knowledgeable when approaching trans individuals and their specific health needs, whether it may be related to hormone access for medical transitioning or to assist those experiencing distress related to discrimination as a gender minority.^{3,7} Minority Stress Theory is an often-used framework to describe differential health care outcomes for sexual orientation and gender expression communities.⁸ This framework describes how psychological stress manifests into physiological symptoms in minority groups, outlining social and psychological factors and their relation to the conflicting values between minority and dominant groups in social environments.^{7,8} Chronic stress related to stigmatisation, prejudice and internalised transphobia can lead to a greater likelihood of psychological distress and adverse physical health outcomes. A lack of formal acknowledgement surrounding trans communities in academia and health care education (e.g.

informational) and limited human rights protections (e.g. institutional) explains a concept known as erasure.⁴ Occurring passively or actively, erasure in healthcare contributes to the systemic barriers trans people face.⁴ This analysis explores a local sample of trans peoples' experiences in primary care (PC) settings, identifying socio-demographic- and psycho-social factors associated with gender identity disclosure to providers, comfort and communication with providers. This study furthers our understanding of the differential experiences of trans people in healthcare and examines the ways in which certain psycho-social factors moderate discussions around gender identity. We hope to add to the body of scholarship aimed at increasing trans visibility in healthcare and knowledge in medical education.

Materials and methods

The Outlook Study

The OutLook Study was a community-based research project in the Region of Waterloo that explored the social exclusion, health and well-being of lesbian, gay, bisexual, trans, queer (LGBTQ) individuals. Responses were collected from May to November 2016 via an online survey. Detailed study descriptions are described elsewhere.⁹ The sample included 526 LGBTQ individuals, of which 112 identified as trans. 'Trans' was coded as answering yes to the following questions: Are you transgender, transsexual, gender variant, or a person with a history of transitioning sex or gender? The study was reviewed and approved by the Research Ethics Board at Wilfrid Laurier University (REB#4875).

Sampling procedures

Eligibility criteria included: (1) being aged 16 years or older; (2) identifying as a sexual and/or gender minority and; (3) either attending school, working or residing, in the Region of Waterloo, Ontario, Canada. Individuals were recruited via several methods including online and printed advertisements and referrals. Informed consent was obtained once participants read a letter of information and agreed to proceed with the remainder of the survey.

Measures

Demographics

The following variables were collected: age (continuous), birth presumed gender [assumed male at birth (AMAB), assumed female at birth (AFAB)], sexual orientation (gay, lesbian, bisexual, queer, heterosexual, asexual, not sure, other), educational attainment (ranging from high school not completed to postgraduate degree completion), employment status (full- or part-time, not employed and looking for work,

not employed and not looking for work, or receiving Ontario Disability Support Program (ODSP) income support), household income (range of incomes, including participants who did not want to disclose their income), birth country (Canada, outside Canada), relationship status (single, in a monogamous relationship, in a non-monogamous or polyamorous relationship) and ethno-racial identity (self-identify by fill in the blank). The descriptors for ethno-racial identity were defined as 'White' and 'Racialised' after the variable was found not significantly associated with all health outcomes. Further analysis of specific ethno-racial identities was not explored for this reason.

Health-related factors

Data on having a primary care provider (PCP), disclosure of gender identity to providers, comfort with, and talking to providers were collected, with the latter three used as dependent variables for regression analyses. A check-all-that apply list of discriminatory experiences related to gender identity in a PC setting was asked (Table 1). Having to educate a PCP about trans-related needs was also measured (ranging from providing a lot, some, a little, to not providing).

Psycho-social factors

Experiences with transphobia including transphobic discrimination and harassment was measured with a 10-item scale (Cronbach's $\alpha = 0.89$) adapted from Diaz *et al.* (2001) by Trans PULSE Ontario.^{9,10} Social support (from family, friends and a special person) was measured using the Multidimensional Scale of Perceived Social Support (Cronbach's $\alpha = 0.91, 0.93, 0.96$).¹¹ Self-esteem was measured using the Rosenberg Self-Esteem Scale (Cronbach's $\alpha = 0.89$).

Data analysis

Analyses were completed using SPSS (ver. 24.0, IBM Corp., Armonk, NY, USA). Descriptive statistics were summarised for continuous and categorical variables. Bivariate analyses calculated prevalence ratios (PR) for our outcome variables (three dependent variables, as mentioned above: disclosure, comfort and talking variables) and predictors using a modified Poisson regression method with robust variance estimators, which provided more valid estimates for non-rare outcomes.¹² Multivariate regression then modelled outcome variables using predictors significant at $P \leq 0.10$.¹³ Instances of trans discrimination were not modelled at the multivariable level due to interpretive issues related to temporality. Final models with transphobia retained were created for all outcomes to explore this association, controlling for other significant factors. Final significance was determined at the $\alpha < 0.05$ level.

Table 1. Socio-demographic and health-related characteristics of trans participants in the OutLook Study.

Variable	Frequency	n (%)
Age (years)		
16–24	63	56.3
25–39	40	35.7
40+	9	8.0
Birth presumed gender		
Assumed male at birth	39	34.8
Assumed female at birth	70	62.5
Missing	3	2.7
Sexual orientation		
Gay or lesbian	11	9.8
Bisexual or queer	58	51.8
Heterosexual/asexual/not sure/other	41	36.6
Missing	2	1.8
Gender identity		
Boy or man	17	15.2
Girl or woman	18	16.1
Female to male	20	17.9
Male to female	12	10.7
Trans man or boy	20	17.9
Trans woman or girl	19	17.0
Feel like a girl sometimes	15	13.4
Feel like a boy sometimes	17	15.2
T girl	4	3.6
Two-spirit	10	8.9
Intersex	4	3.6
Crossdresser	5	4.5
Genderqueer	40	35.7
Bigender	6	5.4
Education		
High school not completed/High school graduate, Not sure	34	30.4
Some postsecondary (college, trade school, university)	31	27.7
Postsecondary graduate, graduate degree, or post-graduate degree	44	39.3
Missing	3	2.7
Employment		
Full-time	34	30.4
Part-time	26	23.2
Not employed and looking for work	25	22.3
Not employed and not looking for work	12	10.7
On disability	12	10.7
Missing	3	2.7

(Continued on next column)

Table 1. (Continued).

Variable	Frequency	n (%)
Income (household, \$CAN)		
<\$20 000	29	25.9
\$20 000–\$49 999	29	25.9
\$50 000–\$79 999	24	21.4
\$80 000+	12	10.7
Rather not say	17	15.2
Missing	1	0.9
Born in Canada		
No	10	8.9
Yes	99	88.4
Missing	3	2.7
Ethno-racial group		
White	85	75.9
Racialised	14	12.5
Missing	13	11.6
Relationship status		
Single	41	36.6
In a monogamous relationship	32	28.6
In a non-monogamous or polyamorous relationship	35	31.3
Missing	4	3.6
Do you have a primary care provider?		
Yes	101	90.2
No	10	8.9
Missing	1	0.9
Have you told your primary care provider about your gender identity?^A		
Yes	55	54.4
No	44	43.6
Missing	2	2.0
Do you talk to your primary care provider about your gender identity?^A		
Yes	44	43.6
No	56	55.4
Missing	1	1.0
Felt comfortable sharing gender identity with provider^A		
Yes	62	61.4
No	38	37.6
Missing	1	1.0
Experiences in a primary care setting^{A,B}		
Refused to see you or ended care because you were trans	4	4.0
Used hurtful or insulting language about trans identity or experience	13	12.9
Refused to discuss or address trans-related health concerns	11	10.9

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Table 1. (Continued).

Variable	Frequency	n (%)
Told you that you were not really trans	9	8.9
Discouraged you from exploring your gender	9	8.9
Told you they do not know enough about trans-related care to provide it	23	22.8
Belittled or ridiculed you for being trans	5	5.0
Thought the gender listed on your ID or forms was a mistake	2	2.0
Refused to examine parts of your body because you are trans	4	4.0
Selected any of the above negative experiences	59	58.4
Educated primary care provider regarding their needs ^A		
Yes, provided a lot	17	16.8
Yes, provided some	20	19.8
Yes, a little	14	13.9
No	47	46.5
Missing	3	3.0
	Mean	s.d.
Transphobia ^A	13.52	6.08
Self-esteem ^A	16.44	4.83
Social support from family ^A	2.97	1.59
Social support from friends ^A	4.50	1.43
Social support from a special person ^A	4.41	1.29

^ASubset of those who responded 'yes' to having a primary care provider.

^BExperiences in a primary care setting were presented as a 'check-all-that apply' list; participants may have selected more than one.

Results

Descriptive statistics

Table 1 outlines socio-demographic, health and psycho-social characteristics of trans participants who are the focus of our analysis. Most participants were aged 16–24 years (56.3%). Almost two-thirds (62.5%) were AFAB. One-third (30.4%) were employed full-time, 23.2% part-time and 10.7% unemployed and not looking for work. The majority (75.9%) identified as white. Roughly one-quarter (28.6%) were in a monogamous relationship.

Most (90.2%) had a PCP, however only 54.4% had shared their gender identity with their provider. Of those with a PCP, 55.4% reported not discussing gender identity-related health information with their PCP, while 61.4% felt comfortable discussing gender identity with their PCP. One-fifth (22.8%) reported their PCP did not know enough about trans-related health to provide care. Half (50.5%) reported having educated their PCP about trans-specific health care needs.

Bivariate associations between our outcomes and factors under consideration are in **Table 2**. Individuals aged

25–39 years and AMAB were more likely to disclose gender identity [RR = 1.87, 95% CI: 1.32, 2.64; and RR = 1.47, 95% CI: 1.04, 2.08, respectively], feel comfortable discussing gender identity-related information [RR = 1.73, 95% CI: 1.27, 2.37 and RR = 1.56, 95% CI: 1.17, 2.09, respectively] and talk about health issues related to gender identity with their PCP [RR = 1.99, 95% CI: 1.26, 3.13 and RR = 1.72, 95% CI: 1.11, 2.69, respectively], relative to participants aged 16–24 years and AFAB counterparts. Participants who were financially supported through ODSP and other social assistance programs were more likely to disclose gender identity to [RR = 1.88, 95% CI: 1.24, 2.87], and discuss it with their PCP [RR = 2.40, 95% CI: 1.45, 3.96], compared to those employed full-time. Participants felt significantly more comfortable discussing gender identity with increased family support [RR = 1.12, 95% CI: 1.02, 1.22]. Instances of transphobia were positively associated with disclosing gender identity [RR = 1.03, 95% CI: 1.01, 1.06].

Table 3 presents multivariable modelled associations for outcomes, controlling for variables bivariately significant at $P \leq 0.10$, with transphobia retained for analytic exploration. The group aged 25–39 years remained positively associated with all three outcomes. Those receiving social financial supports were more likely to disclose and discuss gender identity with their PCP. Familial social support remained significantly associated with comfort discussing gender identity in PC settings. In the multivariable models, transphobia was positively associated with all three outcomes.

Discussion

This analysis explored factors associated with gender identity disclosure in PC settings for a local sample of trans participants, with focus on experiences of transphobia. Age, birth presumed gender, employment status, family support and transphobia were significantly associated with either gender identity disclosure, discussing gender identity related health issues, or comfort sharing gender identity with a PCP. Additionally, a large proportion indicated prior discriminatory experiences with a PCP and a history of educating a PCP about trans-specific health needs.

Transphobia in PC settings was positively associated with all outcomes, controlling for socio-demographic, including birth presumed gender and support variables. Similar to our findings, an Ontario, Canada-based study of trans people found increased transphobia was negatively associated with discomfort, proposing resilience to social stigma and confidence as possible explanations.³ It could also be that individuals experiencing transphobia in cisnormative environments appear gender non-conforming whether they

Table 2. Bivariate associations for trans participants' disclosure of gender identity to their primary care provider; comfort in sharing gender identity with primary care provider; and speaking to primary care provider about health issues related to their gender identity.

Health outcome	Has disclosed gender identity to primary care provider			Is comfortable discussing gender identity with primary care provider			Talks to primary care provider about health issues related to gender identity		
	RR	P-value	95% CI	RR	P-value	95% CI	RR	P-value	95% CI
Socio-demographic									
Age (years)		0.001			0.002			0.009	
16–24	Ref	–	–	Ref	–	–	Ref	–	–
25–39	1.87	<0.001	1.32, 2.64	1.73	0.001	1.27, 2.37	1.99	0.003	1.26, 3.13
40+	0.88	0.782	0.34, 2.25	1.30	0.398	0.71, 2.35	1.17	0.756	0.44, 3.08
Birth presumed gender		0.031			0.003			0.016	
Assumed male at birth	1.47	0.031	1.04, 2.08	1.56	0.003	1.17, 2.09	1.72	0.016	1.11, 2.69
Assumed female at birth	Ref	–	–	Ref	–	–	Ref	–	–
Education		0.690			0.419			0.973	
High school not completed/High school graduate	1.09	0.679	0.73, 1.61	0.93	0.679	0.67, 1.30	1.04	0.895	0.61, 1.76
Some postsecondary (college, trade school, university)	0.89	0.609	0.56, 1.41	0.77	0.213	0.52, 1.16	1.07	0.817	0.62, 1.82
College, trade school, university, graduate, or professional degree	Ref	–	–	Ref	–	–	Ref	–	–
Employment		0.003			0.507			<0.001	
Full-time	Ref	–	–	Ref	–	–	Ref	–	–
Part-time	1.12	0.668	0.66, 1.90	1.36	0.134	0.91, 2.03	0.99	0.974	0.49, 1.98
Not employed, looking for employment	1.17	0.552	0.70, 1.97	1.10	0.678	0.69, 1.75	1.15	0.685	0.59, 2.22
Not employed, not looking for employment	0.94	0.875	0.45, 1.99	0.99	0.972	0.53, 1.86	0.96	0.928	0.39, 2.38
On disability	1.88	0.003	1.24, 2.87	1.32	0.268	0.81, 2.15	2.40	0.001	1.45, 3.96
Ethno-racial Identity		0.798			0.844			0.113	
White	Ref	–	–	Ref	–	–	Ref	–	–
Racialised	0.80	0.798	0.48, 1.76	0.95	0.844	0.56, 1.62	0.22	0.113	0.03, 1.43
Relationship status		0.500			0.967			0.535	
Single	Ref	–	–	Ref	–	–	Ref	–	–
In a monogamous relationship	0.99	0.951	0.61, 1.58	1.02	0.906	0.70, 1.50	0.85	0.599	0.46, 1.56
In a non-monogamous or polyamorous relationship	1.23	0.317	0.82, 1.83	1.05	0.797	0.73, 1.50	1.18	0.502	0.72, 1.94
Income (household, \$CAN)		0.262			0.561			0.562	
Less than \$20 000	1.31	0.452	0.65, 2.63	0.36	0.335	0.71, 2.78	1.23	0.622	0.54, 2.83
\$20 000–\$49 999	1.56	0.190	0.80, 3.01	1.64	0.136	0.86, 3.15	1.24	0.601	0.55, 2.82
\$50 000–\$79 999	0.96	0.908	0.44, 2.10	1.42	0.317	0.71, 2.83	1.10	0.837	0.46, 2.61
\$80 000 or more	1.70	0.141	0.84, 3.43	1.70	0.141	0.84, 3.43	1.78	0.174	0.78, 4.10
Rather not say	Ref	–	–	Ref	–	–	Ref	–	–
Sexual orientation		0.910			0.772			0.675	

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Table 2. (Continued).

Health outcome	Has disclosed gender identity to primary care provider			Is comfortable discussing gender identity with primary care provider			Talks to primary care provider about health issues related to gender identity		
	RR	P-value	95% CI	RR	P-value	95% CI	RR	P-value	95% CI
Gay, lesbian	Ref	–	–	Ref	–	–	Ref	–	–
Bisexual, queer	1.11	0.778	0.53, 2.31	1.17	0.624	0.63, 2.16	1.44	0.662	0.46, 3.40
Straight, asexual, unsure, questioning	1.17	0.685	0.55, 2.46	1.05	0.882	0.55, 2.00	1.25	0.455	0.55, 3.79
Psycho-social									
Family social support									
With increasing social support from family	1.03	0.620	0.92, 1.15	1.12	0.017	1.02, 1.22	1.07	0.366	0.92, 1.24
Friends social support									
With increasing social support from friends	0.92	0.094	0.83, 1.02	0.98	0.709	0.89, 1.09	0.90	0.114	0.79, 1.03
Special person social support									
With increasing social support from a special person	1.02	0.771	0.89, 1.18	1.04	0.500	0.92, 1.18	0.96	0.662	0.82, 1.14
Self-esteem									
	0.99	0.481	0.95, 1.02	1.01	0.558	0.98, 1.04	1.01	0.725	0.96, 1.06
Transphobia									
	1.03	0.015	1.01, 1.06	1.01	0.289	0.99, 1.04	1.03	0.100	0.99, 1.07
Health care related									
Experienced discriminatory events with a primary care provider	0.67	0.020	0.47, 0.94	0.49	<0.001	0.36, 0.67	0.68	0.079	0.44, 1.05
Ever had to educate a primary care provider about trans health issues	2.91	<0.001	1.81, 4.70	2.09	<0.001	1.45, 3.01	2.46	0.001	1.44, 4.18

Bold values represent findings significant at alpha < 0.05.

have socially transitioned or are in the process of medically transitioning,¹ necessitating being without a physician.

Experiences of transphobia should be considered alongside discriminatory experiences in PC settings. Instances of trans discrimination were (bivariately) associated with decreased comfort and likelihood of gender identity disclosure. However, determining whether experiences were with current or primary providers was not ascertainable. Further, it is unclear whether participants sought transition-related medical care, which is an important determinant of disclosure. As previously mentioned, negative experiences can result in healthcare avoidance and under-utilisation, discomfort and feelings of marginalisation.^{2,3} Discrimination during medical encounters reinforces uncertainty in a provider's competence, and perpetuates feelings of anxiety and discomfort.² The use of gender inclusive and neutral language helps to alleviate feelings of stress experienced by trans patients.¹⁴ Trans-inclusive medical spaces and

knowledgeable physicians are considered facilitating factors that enable healthcare access.^{14,15} There is work to be done when it comes to advancing medical education. Currently, medical schools in Canada and USA reportedly spend a median of 5 h and 0 h on LGBTQ+ topics in pre-clinical and clinical education, respectively.¹⁶ This extremely small amount of time devoted to trans health is problematic in that doctors lack knowledge to provide trans patients with comprehensive care, perpetuating the cycle of erasure. There is movement, specifically in some Canadian medical schools, towards integration of LGBTQ+ content across the curriculum, including terminology, history, major health issues and avoiding assumptions.¹⁷

We also found that some socio-demographic variables were significantly associated with our outcomes. AMAB individuals and participants aged 25–39 years were more likely to disclose and discuss gender identity and feel comfortable discussing gender identity-related information

Table 3. Modelled associations for trans participants' disclosure of gender identity to their primary care provider; comfort in sharing gender identity with primary care provider; and speaking to primary care provider about health issues related to their gender identity.

Health outcome	Has disclosed gender identity to primary care provider			Is comfortable discussing gender identity with primary care provider			Talks to primary care provider about health issues related to gender identity					
	RR	P-value	95% CI	RR	P-value	95% CI	RR	P-value	95% CI			
Socio-demographic												
Age (years)		<0.001				0.003				0.003		
16–24	Ref	–	–	Ref	–	–	Ref	–	–	–		
25–39	2.23	<0.001	1.52, 3.26	1.65	0.001	1.24, 2.19	2.45	0.001	1.46, 4.12			
40+	1.17	0.754	0.44, 3.06	1.29	0.446	0.67, 2.51	1.52	0.403	0.57, 4.03			
Birth presumed gender		0.256				0.002				0.160		
Assumed male at birth	1.22	0.256	0.87, 1.72	1.56	0.002	1.18, 2.07	1.40	0.160	0.88, 2.23			
Assumed female at birth	Ref	–	–	Ref	–	–	Ref	–	–			
Employment		0.221								0.070		
Full-time	Ref	–	–	–	–	–	Ref	–	–			
Part-time	1.24	0.326	0.81, 1.90	–	–	–	1.12	0.733	0.59, 2.12			
Not employed, looking for employment	1.36	0.194	0.85, 2.18	–	–	–	1.40	0.242	0.80, 2.48			
Not employed, not looking for employment	1.85	0.105	0.88, 3.88	–	–	–	2.01	0.141	0.79, 5.09			
On disability	1.75	0.031	1.05, 2.90	–	–	–	2.17	0.007	1.23, 3.83			
Psycho-social												
Family Social Support												
With increasing social support from family	–	–	–	1.17	<0.001	1.08, 1.26	–	–	–			
Friends Social Support												
With increasing social support from friends	0.95	0.227	0.87, 1.04	–	–	–	–	–	–			
Transphobia												
With increasing transphobia experiences	1.04	0.002	1.02, 1.07	1.05	0.001	1.02, 1.08	1.04	0.043	1.00, 1.07			

Bold values represent findings significant at alpha < 0.10.

with their PCP. Recent studies report that trans men are more likely to avoid healthcare services than trans women out of fear of discrimination.^{18,19} The intersectionality theory suggests that this can be explained by the fact that trans men are more likely to experience gender disparities innate to the healthcare system based on their birth gender rather than current identity.¹⁹ A large proportion of trans people transition between 25 and 44 years.²⁰ Kattari and Hasche found that an older age of onset for transitioning was associated with a lower likelihood of discrimination or victimisation when accessing services.²¹ Increased age is associated with greater resilience to discrimination and stigmatisation as a result of coping mechanisms developed over the lifetime.¹⁶ The interpretation and internalisation of discrimination may differ by generation²² or perhaps age is associated with a larger social network, the latter of which is protective against psychological distress¹⁶. Compared to those employed full-time, individuals supported through social assistance were more likely to disclose their gender identity and discuss related health issues with their PCP, possibly because they are more likely to seek

trans-accessible healthcare. For example, in Ontario, many community health centres have engaged in further education initiatives to improve trans-accessibility to their services through organisations such as Rainbow Health Ontario.²³ It may also be that individuals receiving ODSP require verification from a healthcare professional, for which disclosing gender identity may be necessary.

Family support enabled comfortability in discussing gender identity in PC settings. Unsurprisingly, studies show family acceptance is independently linked to higher self-esteem in LGBTQ-identified people and offers protective benefits against discrimination. Being out assumes a level of perceived safety, and acceptance leads to reduced stress and better health outcomes.²⁰ Trans people who are supported by their families are more resilient to minority stressors associated with their gender identity.¹⁶

As with any study, strengths and limitations should be considered. This sample, while small in itself, represents a relatively large sample for this geographic region, atypical of samples spanning across much larger regions. Limitations include the study's cross-sectional nature, precluding our

ability to infer temporal relationships between variables. As survey questions regarding PC were binary (yes/no), participants were unable to provide clarification. Further, data on whether PC encounters were related to trans-specific care was not ascertained. Our sample size restricted us from exploring further subgroup analyses for different gender identities, such as genderqueer and non-binary. Moving forward, interviews and focus groups are encouraged to understand the lived experiences of trans people in PC settings, and larger quantitative sample sizes will allow for further subgroup analysis of trans participants and intersecting identities (e.g. race).

Conclusion

This analysis reaffirms how transphobia, negative PC experiences, and other socio-demographics significantly associate with trans patients' perceptions of PCPs. Efforts towards decreasing societal transphobia, encouraging familial support and education, alongside increasing provider knowledge through medical education is necessary to improve health outcomes for trans people. Providers should be aware of the importance of gender inclusive language and medical environments to ensure trans individuals feel safe in clinical settings. Further, providers are to be knowledgeable of contraception options for trans patients and ensure the provision of appropriate and sensitive screening and treatment for sexually transmitted infections, as well prostate, breast and cervical cancers. To mitigate instances of discrimination and improve healthcare access for trans patients, we underscore the necessity to increase medical education of trans health. This study adds to the importance of improving cultural competence among healthcare providers.

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