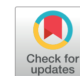
SSM - Qualitative Research in Health 3 (2023) 100284

Contents lists available at ScienceDirect

SSM - Qualitative Research in Health

journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health

Factors affecting communication between transgender and non-binary individuals and general practitioners: Recommendations for inclusive interactions



Robin C. Bos [a,*], Mark J.W. Bos [b]

[a] Center for Molecular Medicine, UMC Utrecht, P.O. Box 85060, HP STR3.217, 3508 AB, Utrecht, the Netherlands
[b] Freudenthal Institute, Utrecht University, P.O. Box 85170, 3508 AD, Utrecht, the Netherlands

A R T I C L E I N F O

Keywords:
Transgender
Non-binary
General practitioner
Theory of planned behavior
Social cognitive theory
Health communication
The Netherlands

A B S T R A C T

Research shows that transgender and non-binary (TNB) individuals frequently experience discrimination and mistreatment in health care settings. These negative experiences cause TNB people to underutilize health care and, when they do utilize it, may affect communication of health information. Moving from social cognitive theory (SCT) and theory of planned behavior (TPB), this study investigated what factors influence pre-, during, and post physician visit communication between TNB individuals and general practitioners (GPs) in The Netherlands. Between March and May 2022, fifteen TNB individuals and ten GPs participated in semi-structured interviews and focus groups about their experiences with GP-TNB interactions. The findings suggest that GPs addressing TNB people, GP knowledge and education, GP office procedures and environment, and social environment (in)directly facilitate or hamper communication. These findings support previous ideas about the influence of factors such as knowledge and social environment on one's behavior, as previously described in SCT and TPB. They also add and specify how pre-determined and novel factors affect whether TNB people feel welcome and comfortable at GP offices and if GPs feel equipped to provide TNB people with quality care. More specifically, to facilitate appropriate health communication, GPs are advised to ask patients about their pronouns, adjust intake forms, and put up TNB-specific posters or a Pride flag in their offices. TNB people are advised to make an introductory appointment to discuss their gender identity. Lastly, TNB topics should be included in medical curricula and online GP resources.

1. Introduction

Effective health communication between physicians and patients is essential to improve patients' awareness of specific health risks, communicate strategies to protect or improve one's health, and help patients make informed health-related choices (Drabble et al., 2003; Ha & Longnecker, 2010). However, (unintentional) discrimination by physicians and an absence of knowledge on needs of specific socio-demographic groups, like the LGBTQ+ community, can lead to ineffective communication of health information and unequal treatment of these patients by creating a barrier to health care (Drabble et al., 2003).

Transgender and non-binary (TNB) individuals - people whose gender identity differs from their birth-assigned sex – experience considerable discrimination in health care settings (James et al., 2016; Kcomt, 2018), despite the increase in public awareness of LGBTQ+ issues due to the gay liberation movement in the 1970s and efforts of protesters rallying for transgender rights. They report cases of overt discrimination, harassment, substandard or forced care, denial of services, and even abuse, as well as more unintentional instances of discrimination like accidently being misgendered and feeling mistreated because of a lack of provider knowledge about their needs or providers showing signs of discomfort (Bauer et al., 2015; Giblon & Bauer, 2017; Kosenko et al., 2013; Rodriguez et al., 2018). Because of these negative health care experiences or merely an anticipation of them, TNB individuals have been shown to avoid seeking care when sick or injured (Cruz, 2014; Jaffee et al., 2016).

By avoiding care, preventable illnesses go untreated, and complications may worsen. Underutilization of care may specifically threaten health status of TNB people because they are at an increased risk of mental health problems and experience more cases of chronic conditions,

* Corresponding author.
E-mail addresses: R.C.Bos-8@umcutrecht.nl (R.C. Bos), m.j.w.bos@uu.nl (M.J.W. Bos).

https://doi.org/10.1016/j.ssmqr.2023.100284
Received 18 November 2022; Received in revised form 29 March 2023; Accepted 13 May 2023
Available online 15 May 2023
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sexually transmitted infections, and substance abuse than cisgendered people (Downing & Przedworski, 2018; Marrazzo et al., 2010; Scheim et al., 2017; Su et al., 2016). Having negative experiences when seeking health care can thus indirectly have large implications for TNB individuals' health. For health care seeking behaviors, Bandura's social cognitive theory (SCT) points out that a person's expectations influence their behavior (Bandura, 1977, 1986). Similarly, Ajzen's theory of planned behavior (TPB) states that a person's attitude towards a given behavior influences their intention to perform said behavior (Ajzen, 1991). This highlights the importance of making health care provider-patient communication TNB-inclusive to make sure TNB people seek and receive appropriate care.

In addition to affecting TNB people's decision making *before* visiting a physician, encountering discrimination may also affect TNB people *during* physician-patient interactions. Feelings of being mistreated may result in ineffective physician-patient communication, which may in turn hinder TNB patients from receiving and understanding essential information they need to make informed decisions about their health and care, as suggested by Redfern and Sinclair (2014). Effective provider-patient communication requires information exchange between physician and patient to foster shared decision-making about patient care (Ha & Longnecker, 2010). In the context of provider-TNB patient interactions, disclosure of one's gender identity is part of the information required to foster effective communication (Friley & Venetis, 2021). However, TNB people report (considering) not disclosing their gender identity due to a fear of discrimination and refusal of care (Friley & Venetis, 2021; Sequeira et al., 2020). Therefore, it is important to improve physician-TNB patient interactions to promote effective health communication and ensure TNB people receive effective health care.

The present study focuses on general health care, since visiting the general practitioner (GP) is the first step a person takes when seeking health care. In addition, it is to be expected that issues concerning GP-TNB communication are more prevalent in general health care than in trans-specific healthcare settings where physicians are accustomed to working with TNB individuals on a daily basis. Based on international literature, Heng et al. (2018) identified several themes influencing TNB patients' experiences with general health care: provider knowledge, use of name and pronouns, provider and staff attitude, GP office procedures and environment, health care avoidance, and patient expectations. From the perspective of physicians, findings of a qualitative study in Canada by Snelgrove et al. (2012) indicate that physicians experience barriers to provide care for trans individuals, mainly because of a lack of trans-specific knowledge. These experiences correspond to those of TNB patients, identified by Heng et al. (2018). The aforementioned themes are not necessarily limited to communication, but they can function as a scaffold for this study's methodology to study what factors might influence GP-TNB communication.

1.1. *Social cognitive theory, theory of planned behavior, and physician-patient communication*

In the field of health communication, it is important to understand which factors influence behavior of target audiences to tailor health communication approaches to a specific audience (Noar et al., 2009). The SCT (Bandura, 1977, 1986) and TPB (Ajzen, 1991) are commonly used theories to understand and explain health-related behaviors. SCT emphasizes that personal factors (e.g., knowledge, previous experiences), behavioral factors (e.g., skills and feelings of competence with the behavior) and environmental factors (e.g., social norms) determine human behavior, and TPB explains how beliefs link to behavior by showing how attitude, subjective norms, and perceived behavioral control influence a person's intentions to perform said behavior.

Considering the potential influence – on care- and health-related behavior – of factors mentioned by Heng et al. (2018), such as a patient's expectations, GP attitude and knowledge, and one's environment, the following factors from SCT and TPB have been incorporated into a proposed theoretical framework (Fig. 1): subjective social norm, expectations, knowledge/self-efficacy/skills, attitude, social environment, and intention. In our study, we use SCT and TPB to investigate if, and if so how, these established factors and potential supplemental factors function in GP-TNB communication specifically, in an attempt to develop a theoretical framework that best describes the influence of environmental, personal, and behavioral factors on GP-TNB communication and future utilization of care.

There is a number of factors prior to, during and after a GP visit that may contribute to the experiences of GPs and TNB individuals that may influence knowledge, attitude, and behavior. Based on the proposed framework, the present study aims to assess the actual factors influencing GP-TNB communication in the Netherlands. The completed theoretical framework, that addresses factors influencing experiences associated with GP-TNB interaction and general care utilization, will be a beneficial addition to existing literature and may function as a foundation to study strategies to make health care interactions more culturally sensitive to minority groups.

1.2. *Research question*

Themes emerging from preexisting literature and the preliminary theoretical framework suggest that several factors may influence experiences and thereby behaviors of GPs and TNB people. To study GP-TNB communication in the Netherlands, the present exploratory interview study has the following research question: What factors in interactions between transgender and non-binary (TNB) individuals and general practitioners (GPs), in the Netherlands, hamper or facilitate health information exchange?

To support this main research question, the following sub-questions are posed.

1. What are the experiences of TNB individuals in the Netherlands when seeking health care from their GP, during the interaction with their GP, and after this interaction?
2. What are the experiences of GPs in the Netherlands when communicating health information to TNB individuals?
3. How can communication between GPs and TNB individuals be TNB-inclusive according to both GPs and TNB individuals?

By researching experiences of both TNB individuals and GPs along with their recommendations to make their interaction more inclusive to TNB people, this study gives insight into potential approaches to foster appropriate communication between physicians and TNB patients as part of an overall strategy to tackle health care inequities experienced by TNB people.

2. Methods

Qualitative methods were used to determine factors that influence communication of health information during interactions between GPs and TNB individuals in the Netherlands. This approach matches the need for patient-centeredness to make health care encounters more inclusive (Prior et al., 2020), because it focuses on experiences of TNB individuals as well as those of GPs to study their interactions and recommendations for optimizing future encounters.

2.1. *Participants*

TNB individuals were recruited through convenience sampling via social media groups for Dutch LGBTQ+ support networks and posts on personal social media accounts of the first author. Later, snowball sampling was used to further recruit participants through the networks of TNB people. Inclusion criteria for TNB participants were (1) being Dutch speaking, (2) being aged 18 years or older, (3) residing in the Netherlands, (4) self-identifying as transgender, non-binary or a gender

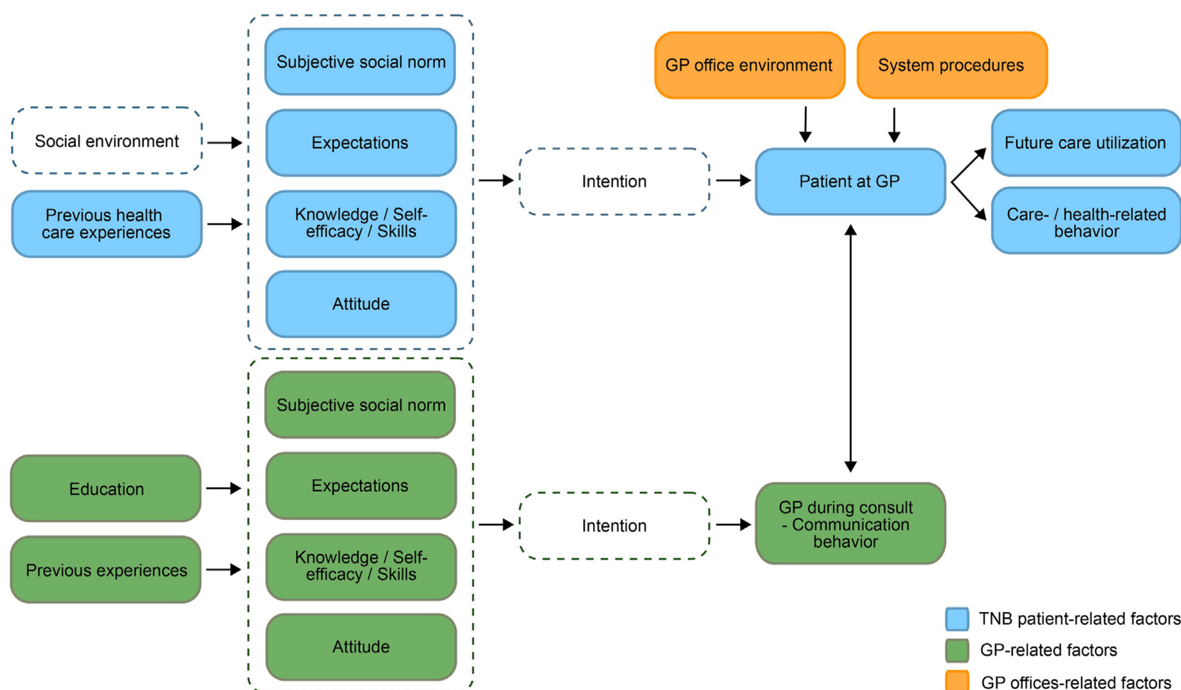

Fig. 1. Proposed Theoretical Framework
The proposed theoretical framework visualizes factors that potentially facilitate or hamper health communication between general practitioners (GPs) and transgender and non-binary (TNB) people. Factors derived from SCT (Bandura, 1977, 1986) and TPB (Ajzen, 1991) are indicated by the dashed lines around the boxes.

identity under those umbrella terms, and (5) that they wanted or tried to receive GP care within the last two years in the Netherlands (but did not need to have experienced GP care).

GPs were recruited through convenience sampling by contacting Dutch GP offices and through social media posts, and snowball sampling to further recruit participants through participants who were contacted earlier. Inclusion criteria for GPs were (1) being Dutch speaking, (2) being aged 18 years or older, (3) having studied medicine in the Netherlands, and (4) working as a GP in a Dutch GP office.

All potential participants who expressed interest and met the inclusion criteria were given information about the purpose and procedure of the study by email. They were informed how the researchers ensured confidentiality and had the possibility to withdraw at any time during the process. After having read this information, if they indicated to be willing to participate, they signed an informed consent form prior to actual participation.

2.2. Instrumentation and data collection

Data were collected via thirteen semi-structured interviews and focus groups between March and May 2022 with a total of fifteen TNB participants and ten GPs. This qualitative approach included two focus group sessions with TNB participants ($n = 6$; $n = 7$); nine individual interviews with GPs, which were held only because of their busy schedules making it impossible to arrange group sessions; and two mixed focus groups ($n = 6$; $n = 6$) with TNB participants and GPs.

Focus group sessions with TNB participants were conducted to identify their general health care experiences. These group sessions were conducted at Utrecht University and audio recorded. The two focus group sessions lasted between 50 and 100 min. The first author used a semi-structured interview guide with open questions to guide a conversation among participants (Appendix A). Based on the proposed theoretical framework (Fig. 1), the interview guide included questions about factors that may affect TNB people's experiences, like GP communication and attitude, social environment, GP office environment, previous experiences, and health care utilization.

Concurrently, online individual interviews with GPs were organized to assess their experiences regarding GP-TNB interactions. Each interview lasted between 20 and 40 min with an average duration of 25 min. Again, a semi-structured interview guide – based on the preliminary theoretical framework – was used to assess GPs' experiences with TNB patients, TNB-specific topics in medical curricula, and what they need to be provide TNB-inclusive care (Appendix B).

Lastly, two online focus group sessions with both TNB participants ($n = 7$) and GPs ($n = 5$) were conducted to explore their recommendations to improve GP-TNB interactions. Participants in these focus group did not have any (established) medical relations. Having TNB individuals and GPs discuss their experiences and ideas together allowed for team-based construction of their recommendations. These interviews lasted between 50 and 60 min. The interview scheme was based on suggestions for improvement that emerged from the previous TNB focus groups and GP interviews (Appendix C). Example topics were including signs to indicate being TNB-inclusive, educating GP assistants, and creating TNB-specific content for (online) resources and medical curricula. All interview schemes were piloted to account for content validity of the instrument, and changes were made accordingly.

During the combined focus groups, to manage possible power dynamics as good as possible, the researcher was tasked to (1) make sure every participant had the opportunity to share their thoughts and to respond to thoughts of others should they want to, and (2) to direct questions to TNB participants first, before asking GP participants for their input. For example, this instruction was added to the question about what a GP should know about being trans or non-binary when a TNB person visits the GP.

2.3. Ethics

The Ethics Review Board of the faculties of Science and Geosciences at Utrecht University provided ethical approval for this study. In accordance with the advice from the ethics committee and the faculty's data

steward, audio files were deleted after transcription and personally identifiable information was pseudonymized in transcripts to maximize confidentiality.

2.4. Data analysis

Data for analysis included verbatim transcripts of interview audio recordings. The first author processed all transcripts using QSR NVivo software (released March 2020). Transcripts were read by the first author allowing for familiarity and recall of the interviews. Next, all transcripts were coded according to the constant comparative method (Boeije, 2002; Glaser, 1965; Leech & Onwuegbuzie, 2011). During the open coding stage, transcripts were split into small units and given labels based on their content. Subsequently, the first author grouped these labels into categories (i.e., axial coding) with themes discussed in the theoretical background in mind to see whether the codes fit into categories based on these themes or should be grouped into novel categories. The last phase of analysis involved development of themes that express the content of these categories (i.e., selective coding).

The first author discussed their codebook and emerging themes with the second author based on the first TNB focus group and first GP interview, and finalized data analysis iteratively in consultation with an independent researcher. The codebook included the following themes: GP-TNB interaction, knowledge and education, environmental factors, type of influence on communication, and other. Data saturation seems to have been reached because no new themes emerged during the second TNB focus group and the last four GP interviews nor were there new recommendations during the final focus groups. Units of analysis about recommendations could all be coded under the themes that were developed prior to analysis of the recommendation focus groups. Transcripts were then coded by a second coder to account for inter-coder reliability. After a second iteration of coding, the Cohen's kappa was 0.98.

3. Results

Experiences and recommendations of GPs and TNB participants covered the following major themes: (a) addressing patients, (b) knowledge and education, (c) system and office environment, (d) peers and society, and (e) moderation and mediation on health care utilization.

3.1. Addressing patients

The most prominent theme was GPs (in)correctly addressing TNB patients. Almost all TNB participants reported encounters with GPs using incorrect pronouns, names, and gendered terms to address someone (e.g., sir/ma'am). They expressed frustration and disappointment about GPs misgendering them (i.e., using incorrect pronouns and gendered terms), especially after repeatedly correcting GPs.

> *I was tired of being constantly misgendered, so then I told it very openly and honestly and then they were like "Oh yes, I will try my best.", but then you're still getting misgendered. That is a pity.* – TNB person

Some TNB participants expressed that being misgendered interferes with GP-TNB communication, because the painful feeling of being misgendered distracts them from the actual content of the conversation. They also voiced noticing that GPs assume their gender identity and pronouns based on their gender expression, which generates a feeling of having to look "trans enough" when visiting a GP. For example, one TNB-participant recalled the following event: "[…] one time I went to my GP wearing a skirt, out of necessity, and they were like 'I thought you were masculine?' […] Then I am like, I visit in a skirt once and get that comment immediately". The opposite situation occurs as well; TNB participants described experiences where their GP put in effort to address them appropriately by asking about their pronouns.

> *For me they do [respect my pronouns]. Because at my GP, actually I think my GP is the first one I told that I had my doubts about my gender, […] when I visited, every time my GP asked: 'What are your pronouns? Have they changed?'. That was nice.* – TNB person

All TNB participants agreed that the use of correct names and pronouns helps them feel accepted, comfortable, and safe. Some of them confirmed that because of that feeling, they are more inclined to visit their GP. Moreover, TNB participants did voice that, even when GPs make mistakes when addressing them, this could be moderated when GPs display an open-minded attitude, characterized by showing compassion. Being open minded and not assuming how someone wants to be addressed was, therefore, voiced by TNB participants, as an, if not the most, important asset of GPs.

> *I never used to go to see a doctor because I always thought […] that I complained too much, and that has nothing to do with being transgender, but because my general practitioner is so open-minded about that, not perfectly but very open-minded, I am like 'Okay I have this, let's go see my general practitioner'.* – TNB person

From the GP's perspective, GPs mentioned struggling with correctly addressing TNB patients, which corresponds with the experiences of TNB participants. Despite good intentions, participating GPs mentioned making mistakes based on whether someone appears to be masculine or feminine. However, in contrast to what was stated by the TNB participants, GPs reported that, in their opinion, struggling to use and report correct pronouns did not interfere with communication of health information. They also did not experience more or less problems regarding TNB patients remembering medical information or following medical advice, compared to cisgender patients. One GP explained: "I do not notice that [they do not remember medical information] at all. They are very conscious people, they come with complaints and they, I think they do follow [the advice]."

Recommendations, mentioned during the mixed focus groups, to support GPs in correctly addressing TNB patients consisted of creating a pleasant start by asking a patient how they want to be addressed during the first GP appointment or using a patient's name instead of sir/ma'am. All TNB patients agreed that GPs should simply ask "What are your pronouns?" or "How would you like to be addressed?". GPs suggested that TNB individuals should make an introductory GP appointment to have an opportunity to discuss their gender identity and needs in more detail. One GP expressed that TNB patients should then clearly state "I am [name], I would like it if you added to my file that I want to be addressed with [name]". In addition to helping GPs in correctly addressing TNB patients, they also highlighted the importance of disclosing one's gender identity and birth-assigned sex because GPs should know whether they should take into account sex-specific tests (e.g., pap smear tests or prostate exams). Overall, TNB and GP participants emphasized the importance of GPs being open-minded and showing initiative to understand TNB-related issues and needs.

> *In the end, it boils down to that open-minded attitude and the willingness to treat one's preferred pronouns, how [they] want to be addressed and how you respond to what people would want to achieve in their transition, in a respectful manner.* – TNB person

3.2. Knowledge and education

Many TNB participants expressed feeling like their GP lacks knowledge about TNB-specific health and health care. This was perceived when GPs had no knowledge about hormone therapy, when a GP prescribed medication for depression because they did not take into account the influence of hormone therapy on mental health, and when GPs did not understand that gender dysphoria (i.e., feeling distressed because of a mismatch between one's biological sex and their gender) can cause menstruation-related issues. As a result, TNB participants explained that

they feel like they have to educate their GP. One participant added: "Of course, you appreciate them not making any statements about something they do not know enough about, but at the same time you hope that they would actually do some research or something." They expressed not feeling supported by their GP, especially when GPs do not put effort into doing some research on TNB-topics.

On the other hand, one TNB participant described a situation where their GP adjusted the information leaflet that comes along with Androgel (i.e., testosterone gel) because they knew that standard Androgel leaflets are aimed at cisgender men with hair loss and that those leaflets would not have the correct information for transition-related use. Here, a GP putting in effort to adjust medical sources of information and showing that they are aware of TNB health facilitated communication of medical information between GP and TNB patient.

All GPs expressed that they lack a certain level of knowledge about TNB-specific health care and health issues. Some GPs reported having trouble communicating health information about TNB-specific topics due to a lack of knowledge about hormones and anatomy. GPs did not recount experiencing difficulties in communicating medical information on topics not related to hormones, genitals, sex, and transition trajectories.

> *When they eventually use hormones, then I feel like I do not know enough about that. So then, I wonder where they are at and how you guide [their process] in a good way. Then I really have to look into it. […] And because I do not know enough about it, it is difficult to counsel [them].* – GP

Participating GPs pointed out that TNB topics (health and communication), were not discussed in their medical and GP-specific training. In some cases, because of this absence of TNB-specific education, two GPs indicated to have obtained a sexology degree while others indicated to depend on expertise groups and specific extracurricular lectures to learn more about TNB health and health care needs.

> *There was maybe a tiny bit [of information] about being intersex […] but that was one time and it was discussed for just for fifteen minutes, and it has nothing to do with gender, only sex. I think about gender, [I was taught] nothing.* – GP

To foster appropriate GP-TNB communication, GPs and TNB participants gave the recommendation of including TNB-specific topics in medical curricula and online GP resources. One GP stated: "I think that especially experiences are helpful. So, from non-binary and transgender [people], that you hear about their experiences with health care." Therefore, they recommended creating sessions where GPs in training can ask TNB individuals about their experiences and needs. GPs and TNB participants added that medical curricula should focus on creating awareness about gender diversity and that TNB-specific medical information should be centralized on a website for GPs and patients. TNB participants did highlight that when GPs consult such resources, they should be aware that guidelines are not a one-size-fits-all.

3.3. System and office environment

In addition to direct GP-TNB interaction, TNB participants voiced being frustrated with patient documentation systems and intake forms. They explained that these online forms generally only have binary gender options (i.e., man/woman) and reinforce issues related to GPs addressing patients, such as cases of misgendering. Especially non-binary individuals do not feel welcome at a GP when they have to register as either male or female.

> *I tried to register at a new [GP office], but I immediately had to register as sir or ma'am and then I thought, okay I'll just keep looking. […] The fact that there is not an extra option keeps me from registering at a new practice or searching for a new GP.* – TNB person

They also described not feeling comfortable at GP offices because GP assistants addressed them incorrectly on the phone or in the waiting area. Moreover, they voiced feeling tired of having to continuously correct GP assistants but "taking away a piece of themselves" if they do not correct them. In addition, TNB participants also reported an absence of LGBTQ+ representation and the unavailability of trans-specific information (e.g., posters and pamphlets). They reported that health-related pamphlets about topics such as periods are never "very inclusive" to TNB people and create a barrier for them and their GP to discuss those topics. All TNB participants agreed that patient documentation systems, GP assistants, and physical GP office environments influence whether they feel accepted and safe enough to visit their GP.

GPs confirmed that their documentation systems do not allow them to register patients as 'other', 'non-binary', or 'trans'. They have to rely on pop-up notices to document patients' pronouns. They explained that they check patient files or pop-up notices to make sure they are aware of someone's sex and gender in order to facilitate communication with their TNB patient. Some GPs did voice that it would be beneficial if their documentation system would allow patients to register as non-binary.

> *I think that in our filing system there should be an option to register non-binary. We have to register man or woman. That is such a shame. There should be an 'other' gender, we do not have that yet. Because when you see 'other gender', you dive into the file, you check how someone identifies and how they want to be addressed.* – GP

Based on the experiences of TNB participants, GPs agreed with the recommendation that intake forms and patient documentation systems should be adapted to allow patients "to be trans or non-binary" by adding an "other" option or by separating sex and gender. GPs also agreed that they should educate GP assistants about communication with TNB patients by discussing gender diversity. Moreover, all TNB participants agreed that it would help them feel safer and more welcome if GP offices would include TNB-inclusive pamphlets and indicators of it being a 'safe space' (e.g., Pride flag stickers or GPs' pronouns) in the office environment and on their website, because it would signify that a GP office recognizes and accepts TNB people.

Furthermore, one GP added that TNB individuals can call GP offices prior to registration to ask whether one of their GPs has an affinity with diversity and inclusivity. All TNB participants confirmed that this recommendation would aid TNB people in finding LGBTQ+ friendly GPs and help them in feeling safe enough to disclose their gender identity.

3.4. Peers and society

Social contacts, like peers, were indicated to influence GP-TNB interactions because these could influence TNB people's expectations about GPs. For example, one TNB participant indicated to be afraid to visit their GP because their TNB partner was treated badly by this GP. They added: "If I would move right now […], I think I would first ask the trans community 'Guys, do you know queer-friendly GPs in this neighborhood?', because otherwise I do not want to visit the GP", indicating that discussing experiences with peers can help TNB individuals find LGBTQ+ friendly GPs. However, learning about negative experiences of peers can also cause TNB people to avoid visiting their GP in general.

On a more macro societal level, one GP explained: "I think that there is mainly just a lack of general awareness but that is a societal [issue] and that the medical world is very much focused on cisgendered people, heteronormative, paternalistic, and focused on the man, the white man." They remarked that we live in a society fixated on gender binarism and that an increase in awareness of gender diversity and needs of gender diverse people needs to occur society wide to reach awareness among GPs. However, TNB-specific education, clinical guidelines, and online resources can support this process.

3.5. Moderation and mediation on health care utilization

While most participating GPs do not experience TNB patients to

postpone visiting their GP more than cisgender patients, TNB participants discussed how the aforementioned factors influence their decision-making regarding care utilization. TNB participants specifically indicated that they delay or avoid visiting GPs because of previous negative experiences or stories of peers about their negative experiences. Some TNB participants explained that they only visit their GP when it is absolutely necessary for their health to do so (e.g., in case of a severe infection). They reported avoiding care because they are afraid of being misgendered (again) or find it difficult to find an LGBTQ+ friendly GP.

> *In general, before going to my GP about [my gender], I frequently heard about many awful experiences with GPs. Like, when you would ask about a referral or any help, that they would make a fuss about it. I think that is the reason why it took me a long time to go to my GP about that, because you hear about a lot of bad GP-experiences.* – TNB person

On the other hand, two TNB participants mentioned that because their GP is open-minded when it comes to gender diversity, they do not feel a barrier to visit their GP. TNB people's experiences with previous GP-TNB interactions and expectations of future interactions, thus, influence their decision about whether they will visit their GP or not.

> *It is mainly the expectation of a negative experience that kind of [leads] to postponement because I don't know at all whether that will really be the case. I just expect that [to happen] because of other experiences I've had at that GP office that aren't necessarily about gender. So, I postpone it all because of the idea that it could happen.* – TNB person

Even though most TNB participants have experienced being misgendered and avoid visiting their GP, they expressed tolerating being misgendered and GPs lacking knowledge when they feel like their GP tries their best and gives them referrals quickly. One participant explained: "They at least use my new name but every time still the wrong pronouns, then I am like 'At least it is something'". They highlighted that, even when GPs use incorrect pronouns and are unknowledgeable, it is most important that a GP is open minded, shows initiative to research TNB-related topics, asks about their patient's needs, and is "on your side".

4. Discussion

The findings of this exploratory qualitative study outline experiences of GPs and TNB individuals in the context of GP-TNB communication in the Netherlands. TNB people and GPs alike face similar and unique barriers when communicating with each other. The main findings of this study show that GPs addressing TNB people, patient registration and documentation systems, GP assistants, GP office environment, peers, and TNB patient expectations were the main factors influencing GP-TNB interactions. To facilitate the discussion, and emphasize the complexity of health communication between GPs and TNB people, the main factors derived from the findings of this study have been added to the visual of the theoretical model and will be discussed accordingly in this section (Fig. 2).

In line with previous international research (McPhail et al., 2016; Poteat et al., 2013), this study found that being (in)correctly addressed greatly influences whether TNB individuals feel comfortable interacting with their health care provider. More specifically, our results seem to align with the findings from Kosenko et al. (2013) and Friley and Venetis (2021) revealing that TNB individuals indeed gauge stigma of health care professionals based on their attitude. Kosenko et al. (2013) describe that trans participants perceive providers as insensitive to gender identities when they use incorrect pronouns or question a patient's gender identity. In addition, Friley and Venetis (2021) indicate that TNB patients contemplate disclosing their gender identity based on their thoughts on

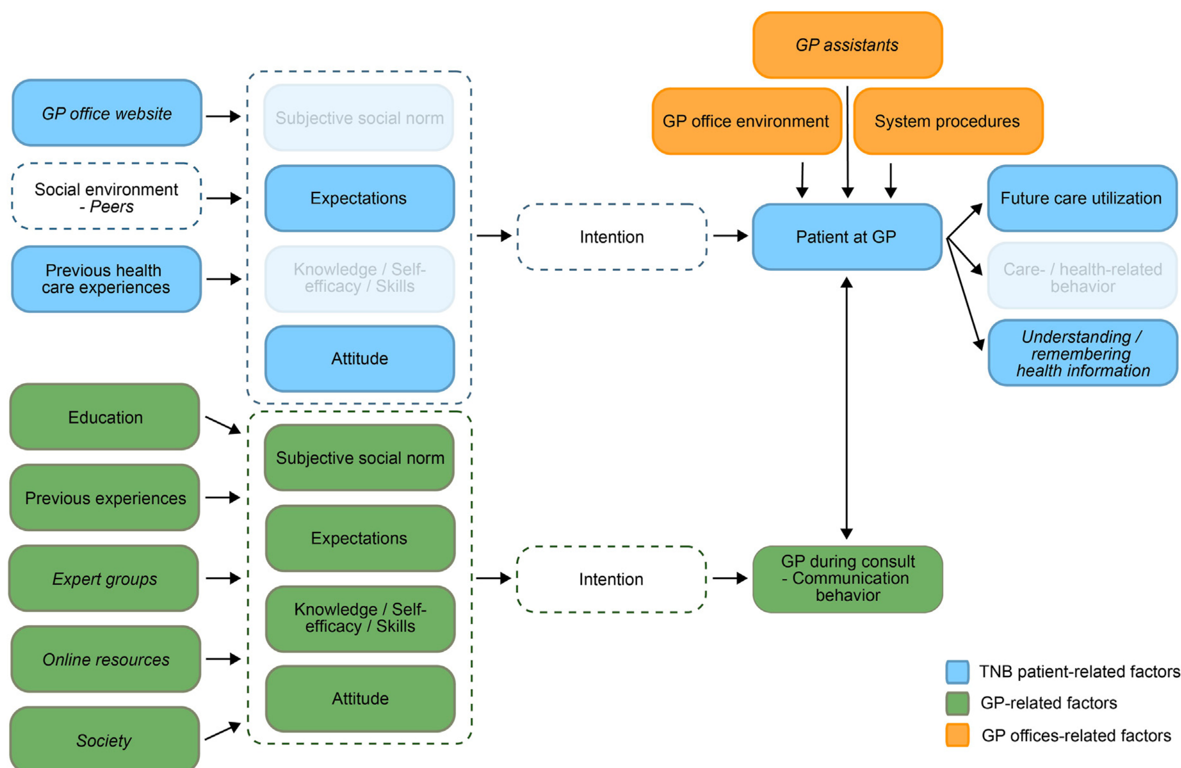

Fig. 2. Adjusted Theoretical Framework
The adjusted theoretical framework visualizes factors that facilitate or hamper health communication between general practitioners (GPs) and transgender and non-binary (TNB) people based on findings of the present study. Factors derived from SCT (Bandura, 1977, 1986) and TPB (Ajzen, 1991) are indicated by the dashed lines around the boxes. The transparent boxes indicate factors that were not discussed or were denied by the findings. Factors in italics are factors that have been added to the framework based on the findings. Factors in a regular font are factors that were confirmed by the findings.

how health care professionals perceive their gender expression and whether providers will perceive them as “trans enough”.

Our study adds that, according to TNB participants, being misgendered by their GP and GP assistants causes TNB patients to avoid seeking care in the future or hampers communication of health information during GP-TNB interactions by distracting them from the information. Findings from this study also show, similar to Ross and Castle Bell (2017), that asking about and using the correct pronouns, names, (non)gendered terminology can aid in creating a more welcoming environment for TNB people. The effect of expectations on TNB patients' intention to seek care and subsequent care-seeking behavior corresponds to the influence of expectations and intention on a person's behavior described by SCT (Bandura, 1977, 1986) and TPB (Ajzen, 1991). What our study adds to our theoretical framework are these explications of the factors of how GPs address patients and their apparent open-mindedness as part of the GP communication behavior, and the behavior and apparent attitude of GP assistants as GP offices-related factors (see Fig. 2).

TNB participants further expressed the need for (online) GP office environments to be more welcoming to TNB people. They recommended adding GPs' pronouns to their website, putting a Pride flag in GP offices, providing TNB-inclusive pamphlets, and putting up posters geared towards TNB people. GPs did agree that they could make the office environment more welcoming to TNB people. In this study, partaking GPs limited this to putting a Pride flag sticker on their door. Our findings seem similar to suggestions made by Vermeir et al. (2017) to make gender-neutral bathrooms available to help trans people feel more comfortable at doctors’ offices. This confirms our findings that putting in effort to include indicators of GP offices being a safe space for TNB people makes them feel more comfortable at GP offices.

However, as covered by numerous news articles, indicators of LGBTQ+ inclusivity and explicitly having gender-neutral bathrooms frequently elicits negative reactions among homophobic and transphobic people (Blumell et al., 2019). Anticipation of such reactions from non-TNB patients may keep GPs from putting up LGBTQ+ indicators. Therefore, the suggestion of one GP to stimulate TNB people to call GP offices prior to registration may be the most feasible strategy to help them assess whether GPs are LGBTQ+ friendly. We incorporated this study's findings covering GP websites, the office environment, and patient documentation systems under ‘GP office website’, ‘GP office environment’, and ‘system procedures’ in our framework, respectively (see Fig. 2).

Furthermore, GPs knowledge and their education were also found to be factors influencing TNB-GP interactions. GPs did not experience difficulties in communicating health information about topics other than those related to TNB and sexual health. However, consistent with previous international research (McPhail et al., 2016; Obedin-Maliver et al., 2011; Snelgrove et al., 2012; Westerbotn et al., 2017), GPs reported a lack of knowledge on TNB health and difficulties in communicating about TNB-specific health information (e.g., hormone therapy).

Not being knowledgeable about TNB health hinders health information exchange directly by compromising GPs' ability to communicate about TNB topics. The reported influence of GP knowledge, skills, and a feeling of competence on TNB-specific health communication is in accordance with the influence of knowledge/skills/self-efficacy described in Bandura's SCT (Bandura, 1977, 1986). The present study added education, expert groups, online resources, and society as factors influencing knowledge/skills/self-efficacy (see Fig. 2). In this study, medical curricula were not assessed expressly, but GPs did spontaneously report an absence of TNB topics in those curricula. Two participating GPs have a degree in sexology and are likely more knowledgeable about gender identities than the general population of GPs. Therefore, the lack of GP knowledge may even be a larger problem in the general GP population than in this sample.

What stood out from the combined focus groups was that TNB participants informed participating GPs on what would make them feel more included, and GPs added what would be practically possible in GP offices. Together their (experiential) knowledge led to their joined recommendation to include small indicators of LGBTQ+ inclusivity on GPs’ doors, inform TNB patients about the option to make an introductory GP appointment or call prior to registration, and centralize TNB-specific medical information on a website. These recommendation-related findings from the combined focus groups may broaden future research and strengthen the theoretical project of making GP-TNB interactions more TNB-inclusive by adding that the influence of the (online) GP office environment on GP-TNB interactions should be considered when studying these interactions.

4.1. Limitations

The results from this study should be viewed in light of some limitations. Sampling bias might have caused a skewed sample of GP participants who were more interested in the topic of inclusivity and LGBTQ+ advocacy. Recruitment emails to GP offices and social media posts stated that participants would discuss GP-TNB communication, which may have sparked the interest of GPs interested in TNB-inclusivity or those identifying as TNB (TNB status of GP participants has not been checked), while discouraging TNB-neutral or transphobic GPs to respond. This limits generalizability of the findings on GP experiences. In addition, this context makes it possible that, unlike this study's sample of GPs, the general GP population does experience retention problems and underutilization of general health care among TNB patients, which could explain the incongruity between the experiences reported by TNB participants and GPs.

Another limitation of this study is that demographic data of participants were not collected. Although this was purposefully done, to maximize pseudonymization of data, this made it impossible to check for interference of ethnicity or socioeconomic status, etc. Previous research indicates that transgender individuals who also belong to an ethnic minority group or have a low income, experience more discrimination in health care settings than their counterparts who do not belong to more than one marginalized community (Kcomt, 2018). Therefore, we propose further research should take on an intersectional approach to explore whether TNB people who belong to multiple marginalized communities have unique GP experiences.

In regard to recommendations given by participants, this study's findings are limited when it comes to recommendations for TNB people. Both GP and TNB participants mainly focused on what GPs could do to make GP-TNB interactions more TNB-inclusive and GPs highlighted that it is their responsibility to improve access to care for TNB people. However, there are things TNB people can do as well. Open-mindedness as a characteristic of the patient was not discussed as a factor in our focus groups, but patient open-mindedness can be expected to facilitate or hamper GP-TNB communication by influencing whether GPs and GP assistants feel invited to ask their patients personal questions about their gender identity, for example. Recommendations for TNB people may then focus on how they can signal that GPs do not have to feel nervous about asking them gender-related questions. By further consulting TNB people and health care providers, future research could investigate what guidelines TNB people can potentially follow when they want to discuss their gender identity and health care needs with health care providers.

Lastly, reflecting on this study's initial focus on health communication, the findings indicate a mismatch between the experiences of TNB people and those of GPs when it comes to hampering of health information exchange during GP-TNB interactions and retention of health information afterwards. While TNB participants reported distraction- and retention-related problems, GPs did not seem to recall or notice these problems among their TNB patient population. To be able to conclude whether certain factors directly hamper understanding and retention of health information, future research should include participatory observations of GP-TNB interactions to objectively assess how health communication takes place during consults.

4.2. Future research

Nonetheless, our results suggest that several factors in GP-TNB interactions create or negate barriers for TNB people to seek general health care and for GPs to communicate with TNB patients about TNB-specific health information. This study is the first to study GP-TNB interaction-related experiences of both GPs and TNB people through the lens of health communication theories in the Netherlands. The findings contribute to the body of literature on TNB people's experiences in health care and health communication between GPs and TNB patients (e.g., Kosenko et al., 2013; McPhail et al., 2016; Ross & Castle Bell, 2017; Snelgrove et al., 2012; Vermeir et al., 2017).

Discussion of this study's findings raises questions about intersectionality of gender diversity with other marginalized identities in the context of GP-TNB interactions as well as what factors directly influence communication of health information between GPs and TNB patients. In addition, the findings raise questions about GP and TNB experiences on a larger scale and what strategies the TNB community can adopt to improve their interactions with GPs. To fully answer the research question of this study, the most pressing need would be to investigate factors hampering understanding and retention of health information. Therefore, future research could focus on observations and conversation analysis (Albert et al., 2018) of GP-TNB interactions by video recording conversations between GPs and TNB patients during consults. Interactions between GPs and cisgender patients should also be observed to study differences and similarities. Retention tests, immediately after GP consults and after a week, would then aid assessment of patients' retention of health information (Wilson et al., 2010). This methodology could aid further understanding and, potentially, quantification of the influence of the factors in the orange boxes of the adjusted theoretical framework on GP-TNB interactions as well as the outcome variables (i.e., future care utilization, understanding/remembering health information) (Fig. 2). This type of research would provide both GPs and TNB people with insight in how to improve health information exchange during GP-TNB interactions.

4.3. Practical implications

Regarding practical implications, both GPs and TNB people can take action and are advised to make quick fixes and/or long-term changes. Quick fixes include the advice for GP offices to add broader gender options to intake forms, and the standard collection of someone's pronouns and chosen name in GP office protocols. GPs are also advised to include an indication of being TNB/LGBTQ+ friendly on office doors, intake forms, and GP websites. TNB people are advised to make an introductory appointment with new GPs to discuss their gender identity.

Similar to McPhail et al. (2022), this study shows that visible indicators, such as a pride flag or an "other" option for gender categories on registration forms, help LGBTQ+ patients feel less nervous about their doctor's appointment; however, we also concur that this should not be tokenism. Indicators do not create the desired safe space in and of itself. Creating safe spaces requires elaborate and collaborate thinking about systemic and societal changes that go beyond GP-TNB interactions.

More long-term changes focus on educational strategies. First, medical curricula should include at least the topics of gender diversity and appropriate communication with TNB people to familiarize GPs with gender dysphoria, the use of pronouns, and where to find additional TNB information, more than they do now. Ideally, medical school courses would include a segment where GPs in training interact with TNB individuals. While in this study both the GPs and TNBs were enthusiastic about this idea of TNB individuals contributing to curriculum development and/or teaching, it is important to realize this is not without barriers. One important requirement would be that, should educational institutions decide to invite TNB individuals to teach medical students about TNB issues and needs of their community in health care settings, these institutions would need to be made aware of how to compensate these lecturers fairly and adequately for their labor. The benefit of organizing this would be giving TNB people a platform to share their needs directly to medical students instead of having cisgender lecturers be the ones to speak out about issues which are not their own, and some would argue, not theirs to teach about.

Secondly, efforts should be made to create quality online resources for GPs, GP assistants, and TNB people, to find information on TNB identities, health, and health care. TNB people may help create these sources of information by providing insight into which medical topics can require an alternative approach when discussing those with TNB people. Even though participants have not mentioned this, TNB people may also benefit from setting up and following a course on how to start a conversation about gender with health care professionals. Together, these changes may, either directly or indirectly, foster communication of health information between GPs and TNB individuals, and help GPs provide supportive care to TNB people.

5. Conclusion

This study explored factors influencing health information exchange between GPs and TNB individuals and aimed to provide an overview of recommendations that may be used by researchers, education developers, and GPs as a starting point to foster TNB-inclusive communication in health care settings. Findings from this study show that GPs and TNB individuals do not seem to experience severe hampering of general medical information exchange. However, the findings suggest that the level of GP knowledge on TNB topics directly hampers or facilitates TNB-specific health information exchange between GPs and TNB patients. Moreover, feeling welcome and accepted indirectly influences communication of health information by affecting a TNB individual's decision to utilize GP care or not. As a result of unpleasant experiences at their GP, TNB individuals may postpone or avoid seeking care because of their expectations of being misgendered or mistreated during future interactions. If TNB patients were to encounter GPs who are more knowledgeable about TNB topics and GP offices where patient documentation systems and physical environments are welcoming to TNB people, they would potentially not revert to health care avoidance. Nonetheless, in line with Westerbotn et al. (2017), participants considered it most important that GPs show an open-minded attitude and initiative to research and learn about TNB topics.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements:

The authors would like to thank Kai Bos, Marjet van den Hoek, and Tamara Schoonderbeek for their support, and all the participants of this study for sharing their experiences and insights.

Appendix. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2023.100284.

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