2018

Exploring Patient Satisfaction among Transgender and Non-Binary Identified Healthcare Users: The Role of Microaggressions and Inclusive Healthcare Settings

Stevie Forbes-Roberts
forb6360@mylaurier.ca

Exploring Patient Satisfaction among Transgender

and Non-Binary Identified Healthcare Users:

The Role of Microaggressions and Inclusive Healthcare Settings

by

Stevie Forbes-Roberts

THESIS

Submitted to the Faculty of Social Work

In partial fulfillment of the requirements

For the degree of Master of Social Work

Wilfrid Laurier University

Spring 2018

© Stevie Forbes-Roberts 2018

Master's Committee:

Advisor: Michael R. Woodford, PhD, Associate Professor, Faculty of Social Work
Ruth Neustifter, PhD, Associate Professor, Couple and Family Therapy Program,
University of Guelph
Robb Travers, PhD, Chair and Associate Professor, Department of Health Sciences,
Wilfrid Laurier University

Abstract

Patient satisfaction is an important indicator of quality of healthcare delivery. Transgender and non-binary (TGNB) people regularly report experiencing discrimination when in healthcare settings and few TGNB-inclusive services are available. Researchers have not examined how discrimination and access to TGNB-inclusive services are associated with patient satisfaction among TGNB healthcare users. Among a convenience sample of TGNB people ($n = 146$) from Canada and the United States, I examined the relationship between patient satisfaction, experiencing microaggressions from primary healthcare providers, and receiving care in a TGNB-inclusive healthcare setting.

The results from a multivariable linear regression suggest that experiencing microaggressions is negatively associated with patient satisfaction while obtaining services from an inclusive healthcare setting is positively associated with satisfaction. These findings emphasize the importance of preparing healthcare providers to engage in inclusive practice with TGNB healthcare users, especially in terms of avoiding microaggressions. They also highlight the importance of creating TGNB-inclusive healthcare settings in fostering patient satisfaction. Researchers, medical professionals, and others working towards health equity, should consider the implications of these findings when developing solutions to improve healthcare access and patient satisfaction.

All of our body-minds are judged in one way or another, found to be normal or abnormal, valuable or disposable, healthy or unhealthy. Our body-minds bring us pleasure and distress, sometimes needing medical care and technology to stay alive and other times needing just a little bit of improving – or so we are led to believe. In the process, most of us become reliant on the medical-industrial complex, snagged by its authority (Clare, 2017, p70).

Creating a space that is welcoming and inclusive for a person who identifies as transgender[1] and non-binary[2] (TGNB) is an important step towards increasing health equity and quality service provision (White Hughto, Reisner, & Chankis, 2015). In response to advocacy and community awareness, some healthcare settings have created and promoted TGNB-inclusive services (Carter, 2017, March 1; Warren, 2015, July 15). Yet, in many regions of North America, TGNB healthcare users face long waiting lists, and often must rely on accessing services in unwelcoming settings.

Patient satisfaction is an important indicator of quality service provision and can aid in measuring a healthcare user's successful navigation of healthcare systems (Bockting, Robinson, Benner & Scheltema, 2004). Increasingly patient satisfaction surveys have become the norm to measure successful healthcare access (Davies, 2013; Donnell-Fink et al., 2011).

---

[1] Transgender is defined, as an umbrella term for anyone who exists opposite or differently than the gender they were designated at birth (McPhail, 2004; White Hughto, et al, 2015).
[2] I define non-binary identity as a person who identifies their gender as outside of the gender binary or who identifies as fluidly moving between multiple genders. Some non-binary persons identify as transgender and some do not (McPhail, 2004; White Hughto, et al, 2015).

Healthcare delivery has the ability to serve healthcare users living across a spectrum of gender identities[3]. Yet, TGNB healthcare users are often excluded by a dominant, "two gender medicine" (Snelgrove, Jasudisius, Rowe, Head, & Bauer, 2012, p. 7) paradigm that only acknowledges the existence of male and female (Bauer, Hammond, Travers, Kaay, Hohenadel, & Boyce, 2009; Bauer, Zong, Scheim, Hammond, & Thind, 2015). Nevertheless, healthcare delivery has the potential to be as diverse as the needs of the healthcare user. Access to health services can be shaped by many factors, including a healthcare provider's prejudices expressed through interactions with TGNB people, which can yield reduced quality of care and/or reduced engagement with healthcare providers (Kosenko, Rintamaki, & Maness, 2015; Nadal, 2013). For those who have accessed health services, receiving knowledgeable and inclusive care is critical; inclusive care, in part, involves the absence of discrimination.

This study is guided by a health equity lens and a critical theory framework. Krieger and colleagues (2010) define a health equity perspective as, "the instrumental use of human rights concepts and methods for revealing and influencing government-mediated processes linking social determinants to health outcomes, especially in relation to the principles of participation, non-discrimination, transparency, and accountability" (p. 748). In an effort to contribute to gender diverse health research, this study explored two main areas among TGNB healthcare users: (1) whether or not healthcare services targeting TGNB healthcare users with a focus on

---

[3] Contrary to how gender is traditionally coded and enforced (i.e., reflecting male/man and female/woman), most research shows gender existing on a spectrum of masculine, feminine and androgyny (Drescher, 2010).

health equity are associated with patient satisfaction, and (2) the impact of microaggressions on

patient satisfaction. This study is primarily concerned with barriers to healthcare related to

microaggressions and possible solutions being addressed by some healthcare settings (Poteat,

German, & Kerrigan, 2013; Spencer & Grace, 2016). A systemic solution for improving health

equity is to create healthcare settings with a focus on TGNB healthcare needs. In short, these

systems do this work by implementing policies and procedures designed to reduce discrimination

and increase awareness (Wylie, Knudson, Khan, Bonierbale, Watanyusakul, & Baral, 2016).

Addressing health equity for TGNB healthcare users requires healthcare systems to take a

leadership role in increasing access. An effective inclusive system promotes and reinforces

healthcare providers and administration improving their ability to provide inclusive services

(Kamamori & Corenelius-White, 2016; Stroumsa, 2014).

Health equity requires policies and procedures that work to reduce discrimination and the

enactment of microaggressions. Microaggressions can have significant effects on a person's

ability to navigate important conversations about healthcare, impeding wellbeing (Kia,

Mackinnon & Legge, 2016; Sterzing, Gartner, Woodford & Fisher, 2017). Sue (2010) defines

microaggressions as "the everyday verbal, nonverbal, and environmental slights, snubs, or

insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative

messages to target persons based solely upon their marginalized group membership" (p. 3).

Microaggressions enacted by healthcare providers have the potential to decrease access to the

very science that is necessary to heal and affirm gender diverse bodies (Nadal, 2013). In addition

to limited research on patient satisfaction specific to TGNB healthcare users (Bocking et al.,

2004; Davies et al., 2013), discrimination experienced by TGNB healthcare users has not be

studied to date in the context of patient satisfaction. A literature review of all publications

available by EBSCO journal database from 2005 forward, using over two dozen relevant search

terms, yielded no research in this area.

Utilizing a lens of health equity and employing critical theory as a framework to better

understand the effects of power in healthcare (Cruz, 2014; White Hughto et al., 2015), I began by

examining patient satisfaction research and other literature relevant to TGNB healthcare users,

describing key findings in the literature, and then finally identified some of the gaps in the

research. Informed by this background, I investigated two central research questions. First, how

might obtaining services from a TNGB-inclusive setting, compared to non-inclusive healthcare

settings or providers, be associated with patient satisfaction? Second, what is the relationship

between experiencing microaggressions from a healthcare provider and patient satisfaction? The

findings of this research can inform gender-inclusive policies and services in support of

actualizing equitable health access for TGNB communities.

Literature Review

TGNB Healthcare

In Ontario and elsewhere, TGNB communities have advocated for improving the

inclusivity and accessibility of healthcare services. In response, some healthcare settings have

implemented policies, procedures and strategies to systemically acknowledge gender diversity as

well as provide services specifically geared to diverse TGNB healthcare needs (Wylie et al.,

2016). This has occurred largely because of the successful documentation of a crisis among

TGNB healthcare users resulting from inaccessible services (Markwick, 2016; Poteat et al., 2013). In a qualitative study in Ontario, Canada, 13 healthcare providers were interviewed, and shared that a lack of transgender-specific knowledge and difficulty integrating a diagnostic versus a pathologizing approach was a significant barrier to improved care (Snelgrove et al., 2012). Research in Canadian and American medical schools reveals a median of five hours dedicated to transgender healthcare education out of the entire curriculum (White et al., 2015). Of the 4,262 medical students surveyed in Canada and the United States, two-thirds rated the LGBT curriculum as fair, poor or very poor.

Research suggests that transgender service users who perceive physicians to have received little or no training on transgender-inclusive health provision generally do not access healthcare services (Bauer et al., 2009; Bauer et al., 2015; Cruz, 2014). TGNB persons report primary healthcare providers refusing to provide care with the assumption that all TGNB service users require "specialty care" (Bauer et al., 2009; Giblon, & Bauer, 2017; Poteat et al., 2013). Not only do healthcare settings (systems and individual providers) need to improve their knowledge, but also healthcare settings need to welcome TGNB healthcare users by reducing experiences of discrimination and acknowledging that many of their needs are not related to their gender identity (Snelgrove et al., 2012). While Kanamori and Cornelius-White (2016) found healthcare providers held transgender-positive attitudes across professions, they also questioned why there is not greater uptake in increasing knowledge and capacity to provide TGNB-inclusive healthcare.

In Ontario, Canada, the call by TGNB advocates within the community to end systemic oppression has been loud: TGNB inclusive healthcare needs to be a part of all healthcare (Fraser, 2016, March 6). The literature has documented high rates of suicidality reported by healthcare users during a critical time between requesting gender affirming services and then subsequently experiencing very long waitlists (Bauer, Scheim, Pyne, Travers, & Hammond, 2015). Advocacy efforts, coupled with long wait lists, have fueled increased governmental and public awareness, resulting in more healthcare providers, AIDS service organizations, and community health centres opening their doors to welcome TGNB healthcare users (Carter, 2017, March 1; Warren, 2015, July 15). LGBTQ+ advocacy organizations like Rainbow Health Ontario have been at the forefront of mobilizing to provide doctors with the resources required to offer basic healthcare when they believe their own resources are not enough (Rainbow Health Ontario, n.d.).

Inclusive policies and subsequent inclusive organizational practices work to prioritize TGNB-inclusive healthcare improvements (Farrer, Marinetti, Kuipers Cavaco, & Costongs, 2015). For instance, anti-discriminatory policies can prevent discrimination and provide a mechanism to address discrimination when it occurs (Lombardi, 2007). Within the healthcare setting, management teams and top-level decision makers move the agenda forward by setting goals and desired outcomes for change in tandem with TGNB advocacy organizations (Chircop, Bassett, & Taylor, 2013). Initiatives are implemented such as revising forms to document more than two genders, asking all healthcare users for pronouns (not assuming), updating bathroom signage, creating TGNB-inclusive website language and graphics, as well as creating opportunities for peer support initiatives. In addition, human resource departments may initiate

improved recruitment of providers by asking about TGNB knowledge. Healthcare settings may establish regularly scheduled TGNB-inclusive trainings. Such systems inform as well as support individual providers to deliver quality TGNB-inclusive care (Spencer & Grace, 2016). Without inclusive settings, TGNB inclusive providers may not have the resources at hand to provide the care that will result in high rates of patient satisfaction (White-Hughto et al., 2015).

Patient Satisfaction

Patient satisfaction is currently a well-accepted tool by healthcare systems to measure successful service (Donnell-Fink et al., 2011). Patient satisfaction primarily focuses on the provider as the locus of much of the reported experience. Patient satisfaction as a concept, integrates a patient-centred approach, positioning the healthcare user as a "consumer" in the system. Bockting and colleagues (2004) reported high rates of patient satisfaction when examining differences between transgender and cisgender patients at a university sexual health centre. They also utilized patient satisfaction to compare scores over time and between groups. In this effort, they adapted services to meet the specific needs of the transgender students who accessed gender affirming services as well as primary healthcare. Davies and colleagues (2013) adapted Bockting and colleagues' patient satisfaction scale for use with patients at a gender identity clinic in England ($N = 178$). This survey included the question, "how satisfied are you with the provision of hormone treatment from you general practitioner?" On average (using a five-point likert scale), patients were relatively satisfied ($M = 4.08$). Patient satisfaction has worked effectively in these TGNB-inclusive settings and healthcare users responded favourably to their implementation. In another study, out of 415 TGNB participants across Germany, 97%

stated they would like to give feedback on their patient satisfaction (Eyssel, Koehler, Dekker, Sehner, O Nieder, 2017).

Already much of the research specific to TGNB healthcare users documents how inclusive healthcare provision might differ in practice from exclusive provision. Transgender healthcare users state the value of providers who are warm, open and affirming (Kosenko, 2015). A meta-analysis by Redfern and Sinclair (2014) found a healthcare provider's ability to embrace gender diversity, and foster a collaborative relationship through healthcare user feedback, was key to patient satisfaction among transgender patients.

There is a great need to understand the associations between patient satisfaction and experiences of healthcare equity and discrimination. Potentially, for healthcare users who have little choice around provider, or who encounter systems resistant to change, patient satisfaction could provide a "voice" likely to be heard by larger systems of accountability (Spencer & Grace, 2016). When researchers and policy makers look at microaggressions within the provider-user interaction supported by exclusionary systems, patient satisfaction potentially sits at a critical intersection of systems, communication, and inequity.

Microaggressions within Healthcare

Manifestations of discrimination exist on multiple levels within healthcare, through policies, procedures, and organizational norms and climate (Hatzenbuehler, Phelan & Link, 2013). Kia and colleagues (2016) contextualize microaggression within systems through Foucault's notion of governmentality. Governmentality names healthcare systems as a multi-level recruitment of dominant discourses. Theories of governmentality see healthcare settings as

ripe for the enactment of microaggressions. In a large study in the United States ($n = 4049$),

where there is no universal healthcare access, postponing seeking healthcare was significantly

associated with experiencing discrimination, compared to postponing related to lack of

healthcare affordability (Cruz, 2014). In the US-based, National Transgender Discrimination

Survey (n = 4699), participants who reported they are always recognized as transgender had a

positive association with perceived discrimination in healthcare (Rodriguez, Agardh, &

Asamoah, 2018). A healthcare user can encounter microaggressions through the systems they

must navigate in order to access an individual healthcare provider, as well as through interactions

with providers (Bauer et al., 2015).

Trans microaggressions are both the result of power relations and the discursive creator

of binaries (Kia et al., 2016). These can include being misgendered by office reception, asked to

complete a form with boxes for male/female, or called by the "dead" name on their health

insurance card (which may dangerously out them in the public arena of a waiting room) (Redfern

& Sinclair, 2014). Trans-specific microaggressions, whether intentional or not, can work to

enforce systems of cisnormativity through continual insults and invalidations (Nadal et al., 2014).

Research highlights the complexity of addressing healthcare inequity when systems continue to

enforce cisnormativity[4] (Lurie, 2005; Poteat et al, 2013; Redfern & Sinclair, 2014).

Trans microaggressions are everyday comments that communicate, in often subtle ways,

that a TGNB person is stepping outside of norms (Nadal, 2013). A healthcare provider may not

---

[4] Cisnormativity is the concept that systems and interpersonal relations categorize people
exclusively within two genders that hold specific meanings and roles (McPhail, 2004).

notice the effect of a microaggression on a healthcare user. They may not notice the use of "lady" with a non-binary identified person or may refer to a transwoman's anatomy with the word "penis". Microaggressions work as a discursive practice to maintain one group as "normal" and one group as "other" (Sterzing, 2017).

Many TGNB people experience microaggressions frequently throughout the day, and across all life domains, including healthcare. Microaggressions targeting TGBN people within healthcare settings are particularly dangerous. Nadal (2013) created a theoretical model of trans-specific microaggressions including two relevant to healthcare systems: assumption of universal experience and assumption of pathology. For a TGNB service user, an assumption of universal experience can be as difficult to navigate as an experience of complete ignorance from a healthcare provider. A TGNB person may be told by a healthcare provider they need a certain gender affirming treatment they may not want – that there is only one way to transition "properly". Or a TGNB person may be told to receive a psychiatric assessment in order to access gender affirming hormones, implying that they are in need of psychiatric care when there are no mental health concerns. Diagnosis of gender disorder and mental illness in the DSM-5 continues to pathologize a TGNB healthcare user who often must conform to these narratives in order to receive gender-affirming services (Drescher, 2010). A TGNB healthcare user may avoid healthcare altogether due to previous bad experiences (Nadal et al., 2014).

Research documents the negative consequences of microaggressions in healthcare settings. Bauer and colleagues (2015) found that among 356 trans healthcare users in Ontario, encountering a variety of trans-specific negative experiences with healthcare providers was

associated with higher levels of discomfort with seeking transgender-specific care. Some items in the inventory of trans-specific negative experiences (Bauer et al., 2015), similar to trans microaggressions (Nadal, 2013), include being told that you are not really transgender, used hurtful or insulting language about trans identity or experience, or a healthcare provider that refuses to examine your body because you are transgender. Healthcare providers who are truly concerned with health inequity need to look at the roots of discrimination in healthcare: systems reinforce the practice of providers with unexamined implicit biases and cognitive schemas of transphobia and cisnormativity (Nadal et al., 2014). For well over a decade, researchers have made the link between treatment bias and inequity. Much theorizing has led to a better understanding but still requires up-take into practice within healthcare systems (Clark, Veale, Townsend, Frohard-Dourlent, & Saewyc, 2018; Spencer & Grace, 2016).

Summary

A lack of transgender-inclusive healthcare settings and providers combined with the prolific nature of microaggressions based in harmful prescriptions of cisnormativity creates severe health inequity for TGNB persons (Kia et al., 2016). Research is needed to understand how quality healthcare is impacted by microaggressions experienced by a TGNB service user (Bauer et al., 2015). The concept of patient satisfaction offers a lens through which to document successes of TGNB people who access healthcare. By focusing on health equity as a starting point, healthcare services could be tailored to address barriers faced by TGNB communities (Krehely, 2009; Raphael, 2009). By pursuing this line of inquiry, I explore both inclusivity improvements within healthcare settings as well as negative outcomes of experiencing

microaggressions. There are possibilities for improvements when inclusive healthcare settings

work towards increasing patient satisfaction through systemic strategies (Wylie et al., 2016). At

the same time, by not implementing inclusivity, microaggressions within healthcare settings

could be reflected by low patient satisfaction expressed by a TGNB healthcare user.

Conceptual Framework

I employed critical theory as a framework to engage in transformative research that seeks

to improve health equity for TGNB service users. Health equity is an approach that documents

the specific barriers (e.g., microaggressions, lack of TGNB healthcare settings) to wellbeing

experienced by certain communities, and targets interventions through systems change and

government policy (Fredriksen-Goldsen et al., 2014; Krehely, 2009). Such an approach demands

a commitment to real interventions to support change, not simple documentation. It is a matter of

creating processes to address the social-structural inequalities that result in unequal health access

and services (Bowleg, 2017). Within this perspective, health is positioned as a human right

(Yaman & Norheim, 2014). From a standpoint of health equity, human rights, advocacy and

collaboration become intrinsically linked in the solution.

Health equity requires greater utilization and enforcement of human rights legislation to

hold standards of "patient rights" front and centre (Maru & Farmer, 2012). Advocacy efforts then

have a legal hook to mobilize in tandem with front-line efforts for change. In both Canada and

the United States, wide-scale human rights improvements (and setbacks) have mobilized

advocacy efforts often re-prioritizing a focus on health equity (Cossman & Katri, 2017, June 15;

Fausset, 2017, March 30). Ideally, all stakeholders in healthcare are held accountable by human

rights legislation and have a common goal of working towards human rights improvements supported by international law (Fredriksen-Goldsen et al., 2014). This approach prioritizes the participatory involvement of TGNB people as researchers and changemakers, practice communities advocating by and for TGNB people, and regional/national policy-making informed by locally produced knowledge. In this study, I bridge knowledge creation utilizing a health equity lens with the employment of a critical theory framework.

A critical theory framework names inequity and the effects of discrimination by questioning systems of power at work within medical systems (Cruz, 2014; Salas, Sen & Segel, 2010). I aim to engage in knowledge making that considers gender as a system of power that effectively reduces healthcare equity for TGNB healthcare users. Power differentials between healthcare providers and TGNB healthcare users can amplify the effects of stigma in these settings through a multiplicity of binaries: doctor to patient, well to unwell, rich to poor, cisgender to transgender, and so on (White Hughto et al., 2015).

Critical theory informs my research methodology. Bowleg (2017) describes research methodology as a lightbulb and health equity as the electricity. Any research methodology can be transformative if the questions you ask are nurtured in an epistemology that is critical and the research works to shift social relationships in ways that lead to equity and social justice (Mertens, 2009). Transformative research involves collaboration with stigmatized communities in order to create innovative solutions for social change (Brown, Strega, NetLibrary, Inc., & Strega, 2005). Previous research with trans communities has shown the potential for quantitative research methods to be a site of critical engagement (Pyne, Bauer, Hammond, & Travers, 2017).

I commit to a transformative practice by living within a TGNB community and seeking collaboration with the communities I hope to aid with this study. I will be reviewing the findings with a committee of TGNB peers who have likewise committed to holding me accountable to the cause of bringing to light inequity, which has often been ignored by traditional research methods. Browne (2008), writes "normal is, therefore, not merely defined or definable, it is reconstructed through the acts of making statistics".

Specifically, I engaged in a methodology of critical quantitative research, which resists the positivist idea that quantitative research design is inherently scientifically neutral and objective (Stage & Wells, 2014). I positioned this research using a health equity lens; focused on the social justice and human rights implicated in reduced health access and marginalization (Bowleg, 2017; Fredriksen-Goldsen et al, 2014; Reisner et al., 2016). By creating knowledge about microaggressions, inclusive services, and patient satisfaction, I hope to add to the growing literature aiming to improve health equity for TGNB healthcare users.

Reflexivity and Self

Researchers, like all people, are steeped in systems that continuously perpetuate stigma and discrimination; reflexivity is a beneficial tool to overcoming assumptions and addressing privilege. In my practice of reflexivity, I wrap post-structuralist theorists like Foucault (2005) and Butler (2004) around me so I can better understand the dissonance of power relations in the world. I cannot live in this world if I accept that we are all separated inherently into labels of deficit and asset. In the spaces between, I find comradeship and often surprising allies. If my heart is too hurt, I miss these opportunities. Therefore, I am continuously hoping to understand

better, listen to grow my allyship and self-advocacy tools, and find new ways to advocate for

change. I do this work through research, program development, and interpersonal

communication that aims to break down divisions. I address privilege by seeking new ways of

doing by listening to the voices of the most marginalized people in my community and standing

behind and with them in solidarity. I work hard to educate myself on perspectives that privilege

has hidden from me and engage in brave conversations. Part of these conversations requires a

certain level of embracing unknowing as a researcher and utilizing ongoing reflexivity as a much

necessary component of analysis, in order to not re-create narratives of oppression.

      I am particularly committed to social justice goals and the real need for significant

changes in health inequity. This stems from my identities as a gender queer and non-binary

person, an active member of LGBTQ+ social action organizations, and a person partnered with a

transgender man. As a leader in my community, weekly I receive calls and emails requesting

systems navigation, advocacy, and support. I feel great sadness hearing the pain in the voice of

each person who is denied healthcare – one more injustice they face, and knowing that the

choices are so few and the waitlists so long. This research is about healthcare and it is about so

much more. When a person is a recipient of health equity, they may feel a great sense of relief to

know they exist and are deserving of care. Working within these communities, I feel a great

urgency to find a way to create an easy passage to TGNB-inclusive healthcare. The cost of health

inequity is too high. I live in a community where safety planning, phone check-in trees, and big

hugs are a reality. I do this work for myself, for the people I love and for all of us. I do not want

to lose any more people in my community – all the weirdos who make this world magical. I need

to know we are all going to be okay. Sometimes it feels like lifesaving work: to say I see you, this is hard, and we can do it together.

I have worked in HIV/AIDS service organizations and community health centres that have been at the forefront in Southwestern Ontario in offering TGNB-inclusive services. I have seen the changes happening from the inside. I have attended and taught gender diversity workshops to teams of nurses, doctors and frontline workers. I have met medical doctors who understand how important they are on a person's team as an advocate. I have seen the lightbulb in a practitioner's eyes. I, of course notice, when I am misgendered and the person corrects themselves quickly without any need for emotional caretaking. It goes into the bank for me at the end of the day. Remarkably, I feel hopeful. As a social work student and a community worker, I have had influence. I have been invited to speak to health equity and I have created opportunities to bring others into the conversation that needed to be at the health equity table.

Being a white person and a settler on this land, I also occupy spaces of privilege and must work hard to use this privilege for the benefit of change. I believe we are all accountable to create equitable systems that empower individuals to seek positive health outcomes while resisting stigmatizing narratives of blame and shame. My research is part of a process that re-positions the "authority" of knowledge makers (myself included) by reflecting on the significant tensions created by paradigms of privilege and power.

Study and Purpose

I aimed to explore the relationship between TGNB-inclusive healthcare settings, microaggressions and patient satisfaction. Patient satisfaction may be an effective bridge of

communication between healthcare systems, providers and TGNB healthcare users. Healthcare

providers who wish to improve services must also understand that in order to do so requires an

environment free of microaggressions (Kia et al., 2016).

This research will produce knowledge that might be employed by social workers

practicing as members of healthcare teams. As more and more health centers move to multi-

disciplinary models of service delivery, there are more opportunities for social workers to be

leaders in this change (Lerner & Robles, 2016). This research will work towards adding to the

knowledge of health equity for TGNB individuals—an under-represented community within

social work research (Scherrer & Woodford, 2013). I hope this research will serve as a starting

point to better understand the implications of inclusive care and microaggressions in healthcare

settings.

Methods

Participants

The sample consisted of 146 participants. Gender identities included transfeminine

identity ($n = 42$), transmasculine identity ($n = 32$), non-binary and gender queer identity ($n = 57$),

as well as non-binary and transgender identity ($n = 15$). All participants lived either in Canada (n

$= 113$) or the United States ($n = 33$). Almost sixteen percent of participants also held a racialized

identity ($n = 23$). See Table 1 for more information.

Procedures

Sampling. The data were drawn from a larger study being conducted by researchers at

the University of Guelph in collaboration with local knowledge users, LGBTQ2+ organizational

leaders, and TGNB-identified community-based researchers. Through an online survey, the larger project aimed to address numerous research gaps specific to TGNB healthcare. Both the University of Guelph and Wilfrid Laurier University ethics review boards approved the study.

A convenience sample of TGNB-identified people was recruited through online networks in North America. In addition, recruitment occurred at several healthcare agencies in Southwestern Ontario and the Fenway Health Community Center in Boston, Massachusetts, all of which specialize in providing TGNB-inclusive healthcare services. Given the lack of a sampling frame of TGNB individuals, a convenience sample was necessary (Babbie & Benaquisto, 2010). There are estimates that people who identify as transgender in the United States make up between 0.3% to 0.5% of the population (Bauer, Braimoh, Scheim, & Dharma, 2017). However, it is difficult to create a TGNB sampling frame when TGNB people may not feel safe to indicate their identity on census surveys, or gender identity data may not be disaggregated depending on how demographic questions are asked (GenIUSS Group, 2014).

Participants were included in the larger study if they were TGNB-identified, if they were 19 years of age or older, and spoke English. Of the 292 individuals who accessed the online survey, 146 responses were selected for the current study. Individuals were excluded if they did not complete at least 50% of the survey ($n = 128$). Others were excluded because they did not answer microaggressions ($n = 6$) and patient satisfaction ($n = 5$) questions or they indicated they had not received healthcare services in the last year ($n = 3$) or did not have a doctor ($n = 4$). Recruitment occurred over a period of approximately five months (commenced August 15, 2017).

Data Collection. An online survey was conducted because such surveys are an effective way to engage hard-to-reach populations and inquire about sensitive topics (Creswell, 2014; Binik, Mah, & Kiesler, 1999). Moreover, many TGNB persons use online environments to find a community and have extensive online networks (Highleyman, Longmire, & Steinbauer, 2002). The research team utilized these online networks to reach potential participants. Many online communities have rules about research recruitment; thus, access was often limited to sites where I was known as a "safe" person. In other cases, TGNB community leaders posted recruitment materials on my behalf.

Survey Design. A reflexive approach embraced by the research team (including myself) ensured the survey was sensitive to the possible risk of increasing stigma by stereotyping TGNB persons. Skip patterns were utilized to give participants access to questions that directly reference (and affirm) their particular, unique identities and "click all that apply" answers for select questions allowed for complexity. The research team designed the survey by combining the collective experiences and knowledge of the members, as well as committing to health equity. The survey included quantitative and qualitative questions addressing healthcare related to experiences and needs. I utilized variables addressing patient satisfaction, healthcare settings, and microaggressions.

Measures

Patient Satisfaction. Five items assessing patient satisfaction with one's healthcare provider were taken from a Bockting and colleagues' (2004) 12-item scale assessing various aspects of patient satisfaction; other items addressed general satisfaction, such as punctuality and

the handling of phone calls by staff. Sample item: "how would you rate your satisfaction with your health care provider's respect for your opinions?". Respondents selected from 7 responses (1 = very dissatisfied, 2 = mostly dissatisfied, 3 = somewhat dissatisfied, 4 = neither, 5 = somewhat satisfied, 6 = mostly satisfied, 7 = very satisfied). Bockting and colleagues (2004) adapted a scale created by Robinson (1991) to assess patient satisfaction among cisgender and transgender-identified patients at a university health centre. The original scale was used to evaluate service effectiveness and client satisfaction at child guidance clinics (Robinson, 1991). An exploratory factor analysis was used to evaluate the factor structure of the five selected items, used herein, producing a single factor solution. Internal reliability was high, $\alpha = .937$. The theoretical range was 1 to 7; higher scale scores indicate greater satisfaction**.** Distribution of the scores among the sample was normal.

Microaggressions. Microaggressions were measured using Bauer and colleagues' (2012) 11-item index addressing negative experiences with family physicians. Sample item: "refused to see you or ended care because you were trans". Respondents indicated if they had experienced each incident with their primary provider in the last year (no/yes). Bauer and colleagues (2012) did not name this index as a microaggression measurement, rather simply as a negative experience. Upon consulting Nadal's (2013) qualitative research on trans-specific microaggressions, all of the index items had face validity when considering how negative experiences within healthcare settings might work as microaggressions to invalidate and insult a healthcare user's gender identity. As such, I utilize this index to assess encounters with microaggressions.

Responses were summed (theoretical range from 0 to 11) and a higher score was interpreted as having experienced more microaggressions. This index developed by the Trans PULSE team was reviewed by a 16-member community engagement team and found to have good clarity and content validity; no reliability statistic was published. The index had acceptable internal validity among the current sample, $\alpha = 0.69$. Upon analysis, the distribution of the index scores was found to be skewed (skew = 1.52) as scores were clustered and demonstrated leptokurtic (kurtosis = 2.29). Following Bauer and colleagues (2015), who re-coded scores into 3 categories, I conducted exploratory testing with the following re-coded three categories: (1) no microaggressions, (2) one to two microaggressions, and (3) three or more microaggressions. Bivariate analysis showed there was no significant difference in patient satisfaction scores between categories two and three. Thus, I dichotomized microaggressions into having experienced no microaggressions compared to one or more microaggressions.

TGNB-Inclusive Healthcare Setting. This variable was assessed based on how participants' healthcare provider/agency advertised their services when it came to providing TGNB-inclusive healthcare. Participants were able to choose four options: clinic advertises as providing transgender-specific healthcare; healthcare provider is transgender positive but the clinic does not advertise as transgender-specific; healthcare provider does not advertise they are transgender positive but provides transgender positive healthcare; and, the healthcare provider is not transgender positive. This question was created for the study.

Demographics. Demographics included age, country of residence (Canada, United States), gender identity (6 options, including a write-in option), ethno-racial identity (10 options,

including a write-in option), sexual orientation (9 options, including a write-in option), and the highest level of education attained. All of these variables are categorical. With the exception of age and level of education, participants were invited to "click any option" answers to capture diverse identities.

Gender was measured using the two-step approach of sex designated at birth and current gender identity (GenIUSS Group, 2014). Some participants selected a sex designated at birth different from their current gender identity and did not select a transgender identity. These participants were coded as transgender for the purpose of the analysis. As well, some participants indicated both non-binary and transgender (with a binary gender coding). This was coded to reflect their experience living both non-binary and within a binary transgender identity ($n = 15$). The responses for ethno-racial identities were re-coded to reflect seven racial identities. Due to sample size concerns, a dichotomous racialized variable was created. Participants who selected a racialized identity in combination with a white identity were coded as a racialized identity.

In some instances, a high number of participants wrote in the fill-in the blank. These new categories were added to the analysis. For example, "mixed" was added to the ethno-racial variable and "demi-sexual" was added to sexual orientation. Sexual orientation offered a challenge for interpretation with a resulting 35 different combinations of identities (some quite small). Thus, I chose not to include sexual orientation in the bivariate and multiple analyses.

Data Analysis

I used SPSS version 24 (2016) for all analyses. Frequencies and descriptive statistics were conducted for all variables, as well as the items comprising the microaggressions index. T-

tests and ANOVAs were run to examine bivariate relationships between all variables and patient satisfaction. Post-hoc analysis was run for ANOVAs using Hochberg's HSD. Multiple linear regression was used to examine the relationship between satisfaction, TGNB-inclusive healthcare settings and experiences of microaggressions, while controlling for racialized identity. Specifically, to examine the factors associated with patient satisfaction, a sequential linear regression was run. Step one included gender identity and racialized identity. Step two included TGNB-inclusive healthcare setting. Step three included microaggressions (yes or no). Multicollinearity was assessed and no issues were found. Racialized identity was included in the linear regression due to past research indicating that there is an association between racialized identity and lower reported patient satisfaction (Donnell-Fink et al., 2011; Garroutte, Kunovich, Jacobsen, & Goldberg, 2004; Nieman, Benke, Ishman, Smith, & Boss, 2014). No significant bivariate findings were observed for age, country, or education, so these variables were not included in the multiple linear regression.

Dummy variables were created for gender identity and TGNB-inclusive healthcare setting. The reference category for the dummy gender identity was chosen as gender queer and non-binary because patient satisfaction scores for this group were identified in the bivariate analysis as being significantly lower than scores for the other gender identity groups. This group was also the largest group. Likewise, in bivariate analysis, patient satisfaction scores were significantly higher for TGNB-inclusive healthcare setting compared to all other categories (even though it was not the largest group), thus, TGNB-inclusive healthcare settings was chosen as the reference category.

Results

Descriptive statistics for all variables are presented in Table 1. Table 2 outlines the frequency of microaggression items. Bivariate results are displayed in Table 3, and Table 4 presents the multiple linear regression results. On average, participants reported patient satisfaction as 5.50 (SD = 1.58). Higher scores reflected higher satisfaction. Of the 146 participants, 11% reported they accessed TGNB-inclusive healthcare. Many of the participants (26%) reported they accessed a healthcare provider who was TGNB-inclusive but the clinic was not TGNB-inclusive. The majority of the participants (53.4%) accessed healthcare providers who did not state they were TGNB-inclusive but the participants perceived them to be TGNB-inclusive. Some participants reported they accessed healthcare with providers who were not TGNB-inclusive (7.5%). The three most frequently reported microaggressions enacted by providers were (1) "told you they don't know enough about trans-related care to provide it" (n = 51, (2) "used hurtful or insulting language about trans identity or experience" (n = 25), and (3) "refused to provide gender-affirming care" (n = 25). Only one participant reported a provider refused to examine their body.

Bivariate Findings

Bivariate analysis suggests that microaggressions, $t(144)$ = 3.92, p < .001, TGNB-inclusive healthcare setting, $F(4, 141)$ = 11.47, p < .000, as well as gender identity, $F(3, 142)$ = 5.99, p < .01 are significantly associated with patient satisfaction scores. Specifically, participants who experienced any microaggressions reported lower patient satisfaction (M = 4.71, SD = 1.49) compared to those who experienced no microaggressions (M = 5.69, SD =

1.52). Participants who utilized TGNB-inclusive healthcare settings tended to report significantly higher ($M = 6.50$, $SD = 0.64$) satisfaction scores compared to those in which their provider advertises as TGNB-inclusive but not the location ($M = 5.54$, $SD = 1.50$), provider does not advertise as TGNB-inclusive but is inclusive ($M = 5.13$, $SD = 1.44$), and the setting is not TGNB-inclusive ($M = 3.07$, SD 1.22). Concerning gender identity, non-binary and gender queer healthcare users reported significantly lower patient satisfaction scores ($M = 4.61$, $SD = 1.61$) compared to transfeminine healthcare users ($M = 5.84$, $SD = 1.25$). No other significant differences were observed.

Multiple Linear Regression Results

Among the control variables (Step 1), gender was significantly associated with patient satisfaction scores. In particular, compared to non-binary and gender queer participants, scores were significantly higher for non-binary and trans participants as well as transfeminine participants. The model explained 10% of the variance of satisfaction scores.

Step 2, which added TGNB-inclusive healthcare setting increased the explained variance to 30%. Results suggest that compared to participants attending TGNB-inclusive settings, patient satisfaction scores were significantly lower among those whose provider advertises as TGNB-inclusive but the location is not, whose provider does not advertise as TGNB-inclusive but is inclusive, and who attended a healthcare setting which is not TGNB-inclusive. The variables significant in step 1 retained statistical significance.

Microaggressions were added in the final step. Microaggressions increased the explained variance in patient satisfaction scores by 6%. Microaggressions were significantly associated

with patient satisfaction scores, specifically, those who experienced one or more

microaggressions reported significantly lower scores compared to those who did not experience

any microaggressions. All variables significant in the previous step retained their significance in

this model. In this model, according to Cohen's guidelines (Field, 2005), a large effect size was

observed for TGNB-inclusive setting vs. provider is not TGNB-inclusive, $\beta = -.52$, followed by

TGNB-inclusive setting vs. provider does not advertise but is TGNB-inclusive, $\beta = -.38$. There

was a medium effect size for the following variables: provider advertises as TGNB-inclusive, β

$= -.25$, microaggressions, $\beta = -.25$, and transfeminine participants, $\beta = -.23$, and non-binary and

transgender participants, $\beta = .19$.

Discussion

My results at both the bivariate and multivariable levels show that TGNB inclusive

healthcare is associated with higher patient satisfaction scores and that experiencing one or more

microaggressions is associated with lower patient satisfaction scores. TGNB-inclusive healthcare

settings compared to all other healthcare settings demonstrated the largest effect size on patient

satisfaction. Yet microaggressions had a sizeable influence. Complex and interacting systems are

implicated in the profound concern of healthcare inequity for TGNB people: these systems

contribute to the high potential of a healthcare provider engaging in microaggressions (Kia et al.,

2016) and creating services perceived to be non-inclusive to TGNB healthcare users.

Patient satisfaction is a popular indicator of quality healthcare delivery (Bockting et al.,

2004), yet has not been studied thoroughly in the context of discrimination and inequity

(Donnell-Fink et al., 2011). In this study, the average patient satisfaction rating was relatively

high ($M = 5.50$), falling between the categories of "somewhat satisfied" and "mostly satisfied"

on the 7-point scale. High patient satisfaction ratings were also reported in other research on

patient satisfaction, and some researchers have argued that healthcare users have a positive bias

in reporting patient satisfaction (Bockting et al., 2004; Davies, 2013; Donnell-Fink et al., 2011).

Nevertheless, the findings of the current study suggest that even overall relatively high

satisfaction scores are influenced by systemic initiatives and patient-provider interactions.

Davies and colleagues (2013) found 60% of those surveyed at a transgender clinic to be pleased

or very pleased. The participants in the Davies and colleagues (2013) study were all accessing a

TGNB-inclusive setting, and similar to the participants in my study who attended TGNB-

inclusive healthcare settings ($M = 6.50$), they rated patient satisfaction high. Davies and

colleagues (2013) found patient satisfaction as an effective tool to measure areas of improvement

and provide healthcare users with an accessible avenue to provide feedback.

As a growing number of TGNB-inclusive healthcare settings become established,

examining patient satisfaction can help to shed light on service quality (Davies et al., 2013). This

study is important in adding to the literature on patient satisfaction in that it highlights how

interpersonal experiences (namely provider manifested microaggressions) and more structural

factors (namely TGNB-inclusive healthcare settings) can influence patient satisfaction. Patient

satisfaction does have an association with discrimination as measured by TGNB-specific

microaggressions in this study. TGNB healthcare users who experienced microaggressions

reported lower satisfaction compared to those who did not. Patient satisfaction could be utilized as part of the process to measure improvements through health equity interventions.

Amongst the sample, on average participants experienced 1.21 microaggressions (SD = 1.62). Half of the participants did not experience any microaggressions from their healthcare provider. The most frequently reported microaggressions was, "told you they don't know enough about trans-related care to provide it". Bauer and colleagues (2015), likewise, found this to be the most frequently reported negative experience. Healthcare providers who consistently refer TGNB people elsewhere for service, without increasing their own capacity for service delivery, may be increasing harm in the inherent message this practice sends to a service user: their needs are too complex or too "extraordinary" (Kia et al., 2016). Microaggressions added 6% to the explained variance of satisfaction scores in the regression model.

It is important to consider that despite all the barriers to healthcare for TGNB users, some TGNB healthcare users report both high patient satisfaction and do not experience microaggressions. This could be due to the fact that, generally, practitioners across different fields hold favorable attitudes towards transgender healthcare users (Kanamori & Cornelius-White (2016). There is promise that the most reported index item (didn't know enough about trans-related care to provide it), could be solved by expanding the knowledge of the service provider so that they did feel confident to provide inclusive care. Microaggressions are a significant barrier to effective healthcare for TGNB healthcare users, and as such healthcare providers need to be alerted to the important need to reduce their occurrence in order to improve healthcare (Nadal et al., 2014). Rodriguez and colleagues (2018) reflected similar findings in the

National Transgender Discrimination Survey which named three types of discrimination: experiences of sexual abuse, verbal harassment, or being denied equal treatment. It is notable that their study also named denial of healthcare provision as a form of TGNB discrimination.

Eleven percent of participants reported attending healthcare settings that advertise as TGNB-inclusive. Assuming that such agencies provide quality healthcare to an openly acknowledged and welcomed gender diverse population, and staff have received TGNB-inclusive education and training, this would explain high satisfaction among TGNB healthcare users attending these settings. An Ontario, Canada study found that more transgender knowledgeable service provision (as reported by healthcare users) was associated with reduced healthcare user discomfort with physicians (Bauer et al., 2015). These healthcare settings may be actively working towards increasing knowledge and decreasing experiences of discrimination in order to increase health inequity, which may contribute to high rates of patient satisfaction (Snelgrove et al., 2012).

The largest effect size in the final regression model was a TGNB-inclusive healthcare setting, compared to any other setting. Given the importance of patient satisfaction as a quality service indicator and the growing demand for inclusive TGNB-healthcare, this research supports the expansion of such TGNB-inclusive settings as a priority for addressing inequity in healthcare (Cruz, 2014). In order to increase patient satisfaction for TGNB service users, this finding highlights the value of healthcare settings developing policies and procedures towards TGNB-inclusivity, including systemic changes such as hiring practices, intake forms, and bathroom signage, and ongoing trainings for administrative staff and healthcare providers. Among these

various outcomes, training can work towards aiding staff and providers in understanding the

negative effects of discrimination and microaggressions (White-Hughto et al., 2015), thus

helping to ensure unintentional insults, invalidations, and derogatory comments are not part of

the patient-provider interaction (Kia et al., 2016).

There are many accessible toolkits available to healthcare setting motivated to take on the

task of creating inclusive healthcare for TGNB healthcare users. For instance, Rainbow Health

Ontario provides in-person training throughout the province, online resources, and weekly call-in

consultations for providers (Rainbow Health Ontario, n.d). In the United States, The Fenway

Institute provides several resources including ones that address forms and policies, trauma-

informed practice, and best practices for working with both non-binary patients and transgender

patients (National LGBT Health Education Center & The Fenway Institute, n.d.).

Healthcare access is a major issue facing TGNB individuals. Giblon and Bauer (2017)

found that one-third of their respondents had an unmet need, a significantly higher number than

cisgender healthcare users in the same population in Ontario, Canada. Funding and development

initiatives could support healthcare settings that choose to implement wide-scale change to

welcome TGNB service users (Wylie et al., 2016). However, at minimum, education and training

addressing microaggressions is recommended, and can help increase TGNB healthcare users'

satisfaction.

Finally, in many areas, human rights codes have advanced in protecting TGNB healthcare

users (Cossman & Katri, 2017, June 15). TGNB healthcare settings could both publicize these

human rights codes and create patient codes of rights in consultation with TGNB advocacy

groups. Patient codes could address the right to be treated with respect and discrimination-free services. The solution to creating inclusive healthcare requires unique collaborations between healthcare providers, policy makers, grassroots organizations and TGNB healthcare users to best mobilize knowledge and effective strategies (Chircop et al., 2013).

Limitations

Though this study advances new knowledge, its contributions need to be considered in light of its limitations. The sample supported the current analysis, however a larger sample might garner other results or provide nuances not discovered in this study. This study utilized online networks to recruit participants, however people who hold racialized identities were a small proportion of the sample (15.8%). In comparison, other studies recruiting TGNB identified people had lower numbers. The participants who identified as racialized in Ontario's Trans PULSE study ($n = 433$) were just above 12.2% (Giblon & Bauer, 2017) and the participants who identified as racialized in the US-based (The National Trans Discrimination Study: $n = 4699$) made up 5.7%. Even though the current sample had greater racial diversity, like the other studies, groups had to be combined for the analysis, thus, not capturing potentially important within group differences. Moving forward it is extremely important to use an intersectional approach when examining patient satisfaction and other outcomes among people who identify as both TGNB and racialized (Nieman et al., 2014).

Many online networks were suspicious of the recruitment efforts and, justifiably, wanted to protect their members from unwarranted intrusion. The online networks who knew me and other members of the research team were more than willing to promote the survey. In the future,

researchers may want to strengthen working relationships with TGNB communities before commencing a study. Snowball sampling may be helpful when communities are disparate due to geography and intersectional identities.

Health equity is complex and there are inherently many intersectional identities that limit healthcare inclusivity. In examining patient satisfaction, a larger study may be able to uncover greater implications of intersectional identities and health equity. Donnell-Fink and colleagues (2011) found age, income, and racialized identity were associated with lower patient satisfaction.

The original patient satisfaction scale I used had no known reliability alpha, or other psychometric testing (Bockting et al., 2004). The 5-item scale used in this study had strong reliability and was a single-factor, thus reflecting factorial validity. However, the psychometric properties are unknown. Further, research is required to develop patient satisfaction measures for and by marginalized communities (Nieman et al., 2014). Additionally, the measure of TGNB-inclusive healthcare setting is a subjective one. Future research might create a two-step measure that takes into account both a healthcare user's perception of inclusivity combined with an objective index measure based on an inventory of agency policies, procedures, and practices found within TGNB-inclusive healthcare settings. The index might be similar to the gay, lesbian and bisexual (GLB) inclusivity campus resources measure developed by Eisenberg (2002) which included factors such as GLB-inclusive anti-discrimination policies, GLB-specific student organizations, the year the first GLB organization on campus was founded, and the number of GLB courses offered. Such a two-step measure utilized in healthcare settings could offer valuable insight into both the success of a healthcare setting to prioritize certain inclusive

strategies, as well as how these strategies might impact inclusivity as experienced by the healthcare user.

Patient satisfaction scores provide useful and efficient (i.e., low participant burden, low time to complete) insights into the quality of healthcare service. However, they are limited to pre-determined factors contained within the scale. As others have done (Bockting et al., 2004; Davies et al., 2015), combining patient satisfaction with other means of receiving feedback (such as interviews and provider-patient advisory boards) is recommended if the goal is truly service quality.

Finally, there is a huge need for understanding the lived diversity of gender. A limitation of this study was the difficulty in capturing all the nuances of gender represented by the participants' often fluid identities and expressions. I believe it is crucial that future research takes into account the many ways the binary impacts representation in research knowledge. There will never be a simple or empirical way to group complex identities, yet growing research in this area may contribute to better the measures that allow for participants to choose options that accurately reflect fluid and non-binary identities.

Conclusion

Health equity is a broadening research field with improved knowledge of the interventions required for critical change (Farrer et al., 2015; Spencer & Grace, 2016). My hope is that community members and knowledge users will collaborate and effectively implement these recommendations offered above to improve health equity through policy changes, funding sources, human rights advocacy, and wider community interventions to reduce discrimination in

healthcare settings (Chircop et al., 2013). Healthcare systems that practice "two gender medicine" (Snelgrove et al., 2012) and microaggressions within healthcare settings are both a symptom and cause of oppressive systems of gender normativity. Microaggressions can be accounted for through ongoing evaluation of patient satisfaction, however, to truly improve health inequity, TGNB healthcare users need increased access to local TGNB-inclusive healthcare settings. Throughout my learning journey of research and social work academia, I have stayed motived through imagining the possibilities. I imagine a healthcare experience where the expectation of welcoming and inclusive healthcare is real. The risks are evident, the solutions are known and there are clear examples of effective health equity achievements. The time is now for wide-scale implementation of these collaborative solutions. In the process, all of us TGNB healthcare users name ourselves as fabulously deserving quality health care and as powerful advocates for change.

References

Anderson, C. R., & McLachlan, S. M. (2016). Transformative research as knowledge

      mobilization: Transmedia, bridges, and layers. *Action Research, 14*(3), 295-317.

Babbie, E., & Benaquisto, L. (2010). *Fundamentals of social research (2nd ed.).*

      Toronto, ON: Nelson Education Ltd.

Bauer, G., Braimoh, J., Scheim, A., & Dharma, C. (2017). Transgender-inclusive

      measures of sex/gender for population surveys: Mixed-methods evaluation and

      recommendations. *PLoS ONE, 12*(5), E0178043.

Bauer, G.R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K., & Boyce, M. (2009). "I don't

      think this is theoretical; This is our lives": How erasure impacts health care for

      transgender people. *Journal of the Association of Nurses in AIDS Care, 20*(5), 348-361.

Bauer, G.R., Scheim, A.I., Pyne, J., Travers, R., Hammond, R. (2015). Intervenable factors

      associated with suicide risk in transgender persons: A respondent driven sampling study

      in Ontario, Canada. *BMC Public Health, 15*, 525.

Bauer, G.R., Zong, X., Scheim, A., Hammond, R., & Thind, A. (2015). Factors

      impacting transgender patients' discomfort with their family physicians: A respondent-

      driven sampling survey. *PLoS ONE,10*(12).

Binik, Y., Mah, K., & Kiesler, S. (1999). Ethical Issues in Conducting Sex Research on

      the Internet. *The Journal of Sex Research, 36*(1), 82-90.

Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient satisfaction

      with transgender health services. *Journal of Sex & Marital Therapy, 30*(4), 277-94.

Brown, L., Strega, L., NetLibrary, Inc., & Strega, S. (2005). *Research as resistance:*

    Critical, Indigenous, and anti-oppressive approaches. Toronto, ON: Canadian Scholars'

    Press.

Browne, K. (2008). Selling my queer soul or queerying quantitative research? *Sociological*

    Research Online, 13(1), 1-15.

Butler, J. (2004). *Undoing gender.* New York: Routledge.

Bowleg, L. (2017). Towards a critical health equity research stance: Why epistemology and

    methodology matter more than qualitative methods. *Health Education & Behavior, 44*(5),

    677-684.

Carter, A. (2017, March 01). Hamilton a desert for transgender healthcare, but hope is on the

    way. *CBC News.* Retrieved from http://www.cbc.ca/news/canada/hamilton/transgender-

    healthcare-1.4003071

Chircop, A., Bassett, R., & Taylor, E. (2013). Evidence on how to practice intersectoral

    collaboration for health equity: A scoping review. *Critical Public Health, 25*(2), 178-191.

Clare, Eli. (2017). *Brilliant imperfection: Grappling with cure*. Durham,

    NC: Duke University Press.

Clark, B., Veale, J., Townsend, M., Frohard-Dourlent, H., & Saewyc, E. (2018). Non-binary

    youth: Access to gender-affirming primary health care. *International Journal of*

    Transgenderism, 1-12.

Cossman, B., & Katri, I. (2017, June 15). Today trans Canadians celebrate Bill C-16. Tomorrow,

the work begins for us all. *Globe & Mail*. Retrieved from

https://www.theglobeandmail.com/opinion/today-trans-canadians-celebrate-bill-c-16-

tomorrow-the-work-begins-for-us-all/article35324961/

Cruz, T. M. (2014). Assessing access to care for transgender and gender

nonconforming people: A consideration of diversity in combating discrimination. *Social

Science & Medicine, 110*(65-73).

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed

methods approaches (4th ed.).* Thousand Oaks, CA: SAGE Publications.

Danso, R. (2015). An integrated framework of critical cultural competence and anti-oppressive

practice for social justice social work research. *Qualitative Social Work,14*(4), 572-588.

Davies, A., Bouman, W., Richards, C., Barrett, J., Ahmad, S., Baker, K.,….Stradins, L. (2013).

Patient satisfaction with gender identity clinic services in the United Kingdom. *Sexual

and Relationship Therapy, 38*(4*)* 1-19.

Donnell-Fink, L., Reichmann, W.M., Arbelaez, C., Case, A.L., Katz, J.N., Losina, E., &

Walensky, R.P. (2011). Patient satisfaction with rapid HIV testing in the emergency

department. *Annals of Emergency Medicine, 58*(1), S49-S52.

Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history

of homosexuality, gender variance, and the Diagnostic

and Statistical Manual. *Archives of Sexual Behavior, 39*(2), 427-460.

Eisenberg, M. (2002). The association of campus resources for gay, lesbian, and bisexual

students with college students' condom use. *Journal of American College Health, 51*(3), 109-116.

Eyssel, J., Koehler, A., Dekker, A., Sehner, S., & O Nieder, T. (2017). Needs and concerns of transgender individuals regarding interdisciplinary transgender healthcare: A non-clinical online survey. *PLoS ONE, 12*(8), E0183014.

Farrer, L., Marinetti, C., Kuipers Cavaco, Y., & Costongs, C. (2015). Advocacy for health equity. *The Millbank Quarterly, 93*(2), 392-437.

Fausset, R. (2017, March 30). Bathroom law repeal leaves few pleased in North Carolina. *NY Times.* Retrieved from https://www.nytimes.com/2017/03/30/us/north-carolina-senate-acts-to-repeal-restrictive-bathroom-law.html

Feldman, J.L. & Goldberg, J.M. (2006). Transgender primary care. In Bockting, W.O., & Goldberg, J.M. (Eds.), *Guidelines for transgender care.* Binghampton, NY: Haworth Press.

Field, A. (2013). *Discovering statistics using IBM SPSS statistics: And sex and drugs and rock 'n' roll (4th ed.).* London, UK: Sage.

Fraser, L. (2016, March 6). Ontario boosts access for trans people seeking gender confirming surgery. *CBC News*. Retrieved from http://www.cbc.ca/news/canada/toronto/ontario-boosts-access-for-trans-people-seeking-gender-confirmation-surgery-1.3478581

Fredriksen-Goldsen, K. I., Simoni, J. M., Kim, H., Lehavot, K., Walters, K. L., Yang, J., Hoy-

Ellis, C. P., Muraco, A. B. (2014). The health equity promotion model:

Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities.

American Journal of Orthopsychiatry, 84(6), 653-663.

Foucault, M. (2002). *The order of things: An archaeology of the human science*. New York, NY:

Routledge.

Garroutte, E.M., Kunovich, R.M., Jacobsen, C., & Goldberg, J. (2004). Patient satisfaction and

ethnic identity among American Indian older adults. *Social Science & Medicine, 59*(11),

2233-2244.

Giblon, R., & Bauer, G. R. (2017). Health care availability, quality, and unmet need: a

comparison of transgender and cisgender residents of Ontario, Canada. *BMC Health

Services Research*, *17*(1), 283.

GenIUSS Group. (2014). *Best practices for asking auestions to identify

transgender and other gender minority respondents on population-based surveys*.

Herman, J.L. (Ed.) Los Angeles, CA: The Williams Institute.

Hatzenbuehler, M.L., Phelan, J. C., & Link, B.G. (2013). Stigma as a fundamental cause

of population health inequities. *American Journal of Public Health, 103*, 813-821.

Highleyman, L., Longmire, W., & Steinbauer, S. (2002). Conducting research on the

Internet. In A. Ellis, L. Highleyman, K. Schaub, & M. White (Eds.) *The Harvey Milk

Institute guide to lesbian, gay, bisexual, transgender, and queer internet researc*h (pp. 5-

24). New York, NY: Harrington Park Press.

Kanamori, Y., & Cornelius-White, J. (2016). Big changes, but are they big enough? Healthcare

professionals' attitudes toward transgender persons. *International Journal of*

Transgenderism, 17(3-4), 165-175.

Kia, H., Mackinnon, K., & Legge, M. (2016). In pursuit of change: Conceptualizing the social

work response to LGBTQ microaggressions in health settings. *Social Work in Health*

Care, 55(10), 806-825.

Kosenko, K., Rintamaki, L., & Maness, K. (2015). Patient centred communication: the

experiences of transgender adults. In Capuzza, J.C., Spender, L.G., Adams, M. A. (Eds.).

Transgender communication studies: Histories, trends, and trajectories. Lanham, TX:

Lexington Books.

Krehely, J. (2009). *How to close the LGBT health disparities gap.* Washington, DC:

Center for American Progress.

Krieger, N., Alegria, M., Almeida-Filho, N., Barbosa da Silva, J., Barreto, M.L., Beckfield,

J.,…Walters, K.L. (2010). Who, and what, causes health inequities? Reflections on

emerging debates from an exploratory Latin American/North American workshop.

(Editorial). *Journal of Epidemiology & Community Health, 64*(9), 747.

Lerner, J.E., & Robles, G. (2016). The need for social work advocacy to create social justice for

transgender people: a call to action (Report). *Journal of Sociology & Social Welfare,*

43(1), 3-18.

Lombardi, E. (2007). Substance use treatment experiences of transgender/transsexual men and

women. *Journal of LGBT Health Research, 3*(2), 37-47.

Lurie, S. (2005). Identifying Training Needs of Health-Care Providers Related to

Treatment and Care of Transgendered Patients: A Qualitative Needs Assessment

Conducted in New England. *International Journal of Transgenderism, 8*(2-3), 93-112.

Markwick, L. (2016). Male, female and other: Transgender and the impact in

primary care. *The Journal for Nurse Practitioners,12*(5), 330-338.

Maru, D., & Farmer, P. (2012). Human rights and health systems development: Confronting the

politics of exclusion and the economics of inequality. *Health and Human Rights, 14*(2),

1-8.

McPhail, B.A. (2004). Questioning gender and sexuality binaries: What queer theorists,

transgender individuals, and sex researchers can teach social work. *Journal of

Gay & Lesbian Social Services, 17*(1), 3-21.

National LGBT Health Education Center & The Fenway Institute. (n.d.) LGBT Health

education. Retrieved from: https://www.lgbthealtheducation.org/lgbt-
education/publications/

Mertens, D. (2009). *Transformative research and evaluation.* New York, NY: Guilford Press.

Nadal, K. (2013). *That's so gay!: Microaggressions and the lesbian, gay, bisexual, and

transgender community.* Washington, DC: American Psychological Association.

Nadal, K., Davidoff, K., Davis, L., Wong, Y., & Gonsiorek, J. (2014). Emotional,

behavioral, and cognitive reactions to microaggressions: Transgender

perspectives. *Psychology of Sexual Orientation and Gender Diversity, 1*(1), 72-81.

Nieman, C., Benke, J., Ishman, S., Smith, D., & Boss, E. (2014). Whose experience is measured?

 A pilot study of patient satisfaction demographics in pediatric otolaryngology. *The*

Laryngoscope, 124(1), 290-4.

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory

of stigma in transgender health care encounters. *Social Science & Medicine, 84*, 22-29.

Pyne, J., Bauer, G., Hammond, R. & Travers, R. (2017). Taking the pulse, making trans people

count : Quantitative method as social justice strategy in the Trans PULSE project. In H.

Parada & S. Wehbi (Eds.). *Re-imagining anti-oppressive social work research* (pp.3-15).

Toronto, ON: Canadian Scholars' Press.

Rainbow Health Ontario. (n.d.). My guide to caring for trans and gender diverse clients.

Retrieved from https://www.rainbowhealthontario.ca/TransHealthGuide/

Raphael, D. (2016). *Social determinants of health: Canadian perspectives (3rd ed.).*

Toronto, ON: Canadian Scholars' Press.

Redfern, J. S., & Sinclair, B. (2014). Improving health care encounters and

communication with transgender patients. *Journal of Communication in Healthcare, 7*(1),

25-40.

Reisner, S.L., Poteat,T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E.,…Baral, S.D.

(2016). Global health burden and needs of transgender populations: A review. *The

Lancet, 388*(10042), 412-436.

Robinson, B.E. (1991). *Child guidance clinics annual program evaluation reports.* St.Paul,

MN: Wilder Research Center, Amherst H. Wilder Foundation.

Rodriguez, A., Agardh, A., & Asamoah, B. (2018). Self-reported discrimination in health-care

settings based on recognizability as transgender: A cross-sectional study among

transgender U.S. citizens. *Archives of Sexual Behavior, 47*(4), 973-985.

Salas, L. M., Sen, S., & Segal, E.A. (2010). Critical theory: Pathway from dichotomous to

integrated social work practice. *Families in Society: The Journal of Contemporary Social Services, 91*(1), 91-96.

Scherrer, K., & Woodford, M. (2013). Incorporating content on gay, lesbian, bisexual, transgender, and queer issues in leading social work journals. *Social Work Research, 37*(4), 423-431.

Snelgrove, J., Jasudavisius, A., Rowe, B., Head, E., & Bauer, G.R. (2012). "Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Services Research, 12*, 110.

Spencer, K., & Grace, M. (2016.). Social foundations of health care inequality and treatment bias. *Annual Review of Sociology, 42*, 101-120.

Stage, F., & Wells, R. (2014). Critical quantitative inquiry in context. *New Directions for Institutional Research, 2013*(158), 1-7

Sterzing, P., Gartner, R., Woodford, M., & Fisher, C. (2017). Sexual orientation, gender, and gender identity microaggressions: Toward an intersectional framework for social work research. *Journal of Ethnic & Cultural Diversity in Social Work, 26*(1-2), 81-94.

Stroumsa, D. (2014). The state of transgender health care: Policy, law, and medical frameworks. *American Journal of Public Health, 104*(3), E31-8.

Sue, D. (2010). *Microaggressions and marginality: Manifestation, dynamics, and impact.* Hoboken, N.J.: Wiley.

Warren, M. (2015, July 18). Guelph becoming hub for transgender healthcare. *Guelph Mercury*.

Retrieved from https://www.guelphmercury.com/news-story/5739592-guelph-becoming-hub-for-transgender-health-care/

White, W., Brenman, S., Paradis, E., Goldsmith, E., Lunn, M., Obedin-Maliver, J., . . . Garcia, G. (2015). Lesbian, gay, bisexual, and transgender patient care: Medical students' preparedness and comfort. *Teaching and Learning in Medicine, 27*(3), 254-263.

White Hughto, J.M., Reisner, S.L., & Pachankis, J.E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine, 147*, 222-231.

Wylie, K., Knudson, G., Khan, S.I., Bonierbale, M., Watanyusakul, S., & Baral, S. (2016). Serving transgender people: Clinical care considerations and service delivery models in transgender health. *The Lancet, 388*(10042), 401-411.

Yamin, A., & Norheim, O. (2014). Taking equality seriously: Applying human rights frameworks to priority setting in health. *Human Rights Quarterly, 36*(2), 296-324.

Table 1
Descriptive Statistics for Analytic Sample (n = 146)

Categorical variables		*n*	%
Age (in years)	19 -29	75	51.4
	30-39	42	28.8
	40-49	10	6.8
	50-59	11	7.5
	60+	8	5.5
Country of residence	Canada	113	77.4
	United States	33	22.6
Gender identity	Non-binary and gender queer	57	39.0
	Non-binary and transgender	15	10.3
	Transfeminine	42	28.8
	Transmasculine	32	21.9
Ethno-racial identity[a]	Asian	1	0.7
	Black	3	2.1
	East Indian	2	1.4
	Indigenous	12	8.2
	Latinx	2	1.4
	Mixed	1	0.7
	White	125	85.6
Racialized identity	Yes	23	15.8
	No	123	84.2
Sexual orientation[a]	Asexual	27	18.5
	Bisexual	42	28.8
	Demisexual	6	4.1
	Gay	11	7.5
	Lesbian	12	8.2
	Pansexual/polysexual	48	32.9
	Queer	71	48.6
	Questioning/unsure	15	9.6
	Straight	13	8.9
	Two-Spirit	3	2.1
	Missing	18	8.1

[a]These variables do not total 146 as respondents were able to choose multiple options. Each percentage reflects the total of respondents who identify with this option.

Table 1 (cont.)
Descriptive Statistics for Sample (n = 146)

Categorical Variables					*n*	%
Highest level of education	No High School				5	3.4
	High School				44	30.1
	College or Trade School				28	19.2
	University Undergraduate				46	31.5
	University Postgraduate				14	9.6
	Missing				8	5.5
TGNB-inclusive healthcare setting	Clinic advertises as TGNB-inclusive				16	11.0
	Provider advertises as TGNB-inclusive				38	26.0
	Provider does not advertise but is TGNB-inclusive				78	53.4
	Provider and location are not TGNB-inclusive				11	7.5
	Missing				3	2.1
Microaggressions	None				73	50.0
	One or two				49	33.6
	Three or more				24	16.4
Microaggressions	Yes				73	50
	No				73	50
Continuous variable	*M*	*SD*	Minimum	Maximum	Theoretical range	α
Microaggressions[b]	1.21	1.62	0.00	8.00	0.00-11.00	0.69
Patient Satisfaction[b]	5.50	1.58	1.0	7.0	1.00-7.00	0.94

[b]Higher scores describe more microaggressions and higher levels of patient satisfaction.

Table 2

Descriptive statistics for microaggressions (n = 146)

Item	n	%
Refused to see you or ended care because you were trans	10	6.8
Used hurtful or insulting language about trans identity or experience	25	17.1
Refused to discuss or address trans-related health concerns	17	11.6
Told you that you were not really trans	12	8.2
Discouraged you from exploring your gender	14	9.6
Told you they don't know enough about trans-related care to provide it	51	34.9
Belittled or ridiculed you for being trans	7	4.8
Thought the gender listed on your ID or forms was a mistake	15	10.3
Refused to examine parts of your body because you're trans	1	0.7
Refused to provide gender-affirming care	25	17.1

Table 3

Bivariate Analysis of Patient Satisfaction and Study Variables (n = 146)

Variable				
T-Tests	*M*	*SD*	*df*	*t*
Country of residence			144	-0.54
Canada	5.16	1.52		
United States	5.33	1.59		
Racialized identity			144	-.09
Yes	5.17	1.52		
No	5.21	1.59		
Microaggressions			144	3.92***
Yes	4.71	1.49		
No	5.69	1.52		
ANOVA	*M*	*SD*	*df*	*F*
Age (in years)			4, 141	0.58
19-29	5.07	1.50		
30-39	5.23	1.64		
40-49	5.72	1.92		
50-59	5.20	1.55		
60+	5.68	1.75		
Gender identity			3, 142	5.99**
Non-binary and gender queer	4.61	1.61		
Non-binary and transgender	5.69	1.33		
Transfeminine	5.84	1.25		
Transmasculine	5.18	1.68		
Education			4, 132	1.81
No High School	4.08	1.95		
High School	5.22	1.55		
College or Trade School	5.81	1.04		
University Undergraduate	5.19	1.63		
University Postgraduate	4.83	1.88		

Table 3 (cont.)
Bivariate Analysis between Patient Satisfaction and Study Variables (n = 146)

Variable				
ANOVA	***M***	***SD***	***df***	**F**
TGNB-inclusive healthcare setting			4, 141	11.50***
Clinic advertises as TGNB-inclusive	6.50	0.64		
Provider advertises as TGNB-inclusive	5.54	1.50		
Provider does not advertise but is TGNB-inclusive	5.13	1.44		
Provider and location are not TGNB-inclusive	3.07	1.22		
Microaggressions				
None	5.69	1.52	2, 143	7.66***
One or two	4.69	1.47		
Three or more	4.75	1.57		

p < .05. **p* < .01. ***p* ≤ .001.

Table 4

Multiple Linear Regression Exploring Patient Satisfaction Outcomes among TGNB Identified Healthcare Users (n = 143)

Variable	Step 1 *B*	Step 1 *SE B*	Step 1 *β*	Step 2 *B*	Step 2 *SE B*	Step 2 *β*	Step 3 *B*	Step 3 *SE B*	Step 3 *β*
Gender identity									
NBQ vs. NBT	0.99	0.44	.20*	1.01	0.4	.20*	0.96	0.38	.19*
NBQ vs. TF	1.14	0.31	.33***	0.85	0.28	.25**	0.79	0.27	.23**
NBQ vs. TM	0.48	0.33	.13	0.45	0.30	.12	0.54	0.29	.15
Racialized identity									
Yes vs. no	-0.03	0.34	-.01	0.08	0.31	.02	-0.15	0.3	.04
TGNB-inclusive healthcare setting									
Clinic advertises as TGNB-inclusive vs. provider advertises as TGNB-inclusive				-.95	0.4	-.27*	-0.87	0.39	-.25*
Clinic advertises as TGNB-inclusive vs. provider does not advertise but is TGNB-inclusive				-1.25	0.37	-.40***	-1.19	0.36	-.38***
Clinic advertises as TGNB-inclusive vs. provider is not TGNB-inclusive				-3.26	0.53	-.56***	-3.02	0.52	-.52***
Microaggressions									
No vs. yes							-0.77	0.22	-.25***
R²	0.10			0.30			0.36		
F	3.79***			8.29***			9.42***		
F for change in *R²*	3.79			12.99			12.42		

NBQ = non-binary and gender queer; NBT = non-binary and transgender; TF = transfeminine; TM = transmasculine. *$p < .05$. **$p < .01$. ***$p \leq .001$. Based on testing using three different regression models, the results were similar between the microaggressions as a continuous variable, the variable coded as three groups (i.e., none, 1-2, 3 or more) and the dichotomous variable.