


Provider cultural competence and humility in healthcare interactions with transgender and nonbinary young adults

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Abstract

Purpose: Transgender and nonbinary (TGNB) patients experience many barriers when seeking quality healthcare services, including ineffective communication and negative relationships with their providers as well as a lack of provider competence (including knowledge, training, and experience) and humility (engagement in the process of self-reflection and self-critique) in treating TGNB individuals. The purpose of this qualitative study was to identify factors associated with cultural competence and humility that facilitate and impede effective relationships between TGNB young adults and their healthcare providers.

Methods: Data came from individual interviews with 60 young adults aged 18 to 24 from Florida who self-identified as transgender or nonbinary. We analyzed the data using inductive thematic approaches, and a feminist perspective, to identify themes associated with patient-provider relationships.

Conclusions: We identified 4 themes related to patient-provider relationships: (1) Participants indicated effective patient-provider communication and relationships are facilitated by providers requesting and utilizing TGNB patients' correct names and personal pronouns. (2) Participant narratives conveyed their preferences that providers "follow their lead" in terms of how they described their own anatomy, reinforcing the utility of cultural humility as an approach for interactions with TGNB patients (3) Participants discussed the detrimental effects of TGNB patients having to educate their own providers about their identities and needs, suggesting clinicians' competence regarding gender diversity is paramount to fostering and maintaining patient comfort. (4) Finally, participants' responses indicated concerns regarding the confidentiality and privacy of the information they provided to their providers, suggesting a lack of trust detrimental to the process of building rapport between patients and their providers.

Clinical Relevance: Our findings indicate balancing the use of cultural humility and cultural competence during clinical encounters with TGNB young adults can enhance patients' experiences seeking healthcare. Nursing education is often devoid of focus on caring for transgender and nonbinary persons. Additional provider training and education on approaching clinical encounters with TGNB patients with cultural humility

and competence should improve patient-provider communication and relationships, leading to a higher quality of patient care.

INTRODUCTION

In the United States, 1.6% of all adults, and 5.1% of adults under the age of 30 identify as transgender or nonbinary (Brown, 2022). Transgender and nonbinary (TGNB) people remain disadvantaged by their inability to access quality, culturally competent healthcare services (Roberts & Fantz, 2014). Healthcare providers' general lack of experience and education to adequately serve this population (Roberts & Fantz, 2014) has been identified by patients as the most significant factor associated with healthcare utilization disparities among TGNB individuals, compared to their cisgender counterparts (Lerner et al., 2022).

While nursing education may lack a focus on treating transgender persons (Lim et al., 2015), data suggest undergraduate, pre-licensure nursing students largely possess positive attitudes toward providing care to these populations (McKay et al., 2022). However, this has yet to significantly transfer into the direct patient care nurses provide to transgender persons. For example, transgender persons may feel nurses often overemphasize one's transgender or gender nonbinary identity during care interactions (Mikovits, 2022). In addition, transgender persons often perceive nurses as lacking experience and understanding of their unique healthcare needs and feel a sense of burden upon having to educate nurses about their care needs during interactions (Mikovits, 2022). Baldwin et al. (2018) found healthcare providers could facilitate positive interactions, which may increase use of needed healthcare services among TGNB individuals, by possessing and applying prior experience-derived knowledge in the care and treatment of this population.

The relationship between the TGNB patient and provider is threatened by providers' lack of appropriate etiquette, such as improper pronoun use (Lambrou et al., 2020; Mikovits, 2022), incorrect or stigmatizing assumptions regarding patients' gender expression (and by extension sexuality; Pecanac et al., 2021), patients needing to educate providers about their needs (Keiswetter & Brotemarkle, 2010; Mikovits, 2022; Poteat et al., 2013), and patient concerns about confidentiality (Fisher et al., 2018; Pampati et al., 2019). Furthermore, the extant literature on healthcare experiences among TGNB patients has primarily focused on adolescent and older adult populations (Eisenberg et al., 2020; Roberts & Fantz, 2014), which creates a gap in research among TGNB young adults. The National Institute of Medicine and the National Research Council have recommended researchers regard young adults as a specific subpopulation when conducting research related to healthcare policy, planning, and programming (Bonnie et al., 2015; Stroud et al., 2015). Interestingly, young adults represent the age group most likely to identify as TGNB (Brown, 2022) and seek medical care related to gender transition (Lane et al., 2018). However, this subpopulation has less access to preventative care than those in other age groups (Neinstein & Irwin, 2013), even though they are more

likely to engage in risk-taking behaviors (e.g., tobacco and drug use; Strutz et al., 2015).

Theoretical considerations

Patient-provider relationships

The concept of patient-provider relationships emphasizes the role this ongoing relationship can have in patients' medical trajectories such as whether a patient continues to receive care and a provider gives quality care (See Kaba & Sooriakumaran, 2007 for a review). A variety of distinct provider-related factors can enhance or impede effective patient-provider relationships. Perceived caring, competence with a patient's care, effort in maintaining trust, and shared power and goals with a patient, can all promote a patient's trust within a patient-provider relationship (See Murray & McCrone, 2014 for an integrative review). In contrast, providers' negative attitudes, cognitive biases, and resultant behaviors toward stigmatized or marginalized patients (e.g., LGBTQ+ people, people of color, and people living with HIV) can negatively impact the quality of care these patients receive. Providers' negative attitudes toward certain groups can preclude members of these groups from sharing important healthcare-related information and behaviors [e.g., discussing sexual health problems with a provider (Gioia et al., 2021); discussing sexual identity with a provider (Ogden et al., 2019)] and negatively affect their health outcomes (e.g., Asare et al., 2019). Research with individuals living with HIV showed that worse communication with providers occurred when patients felt judged or misunderstood, lacked trust in their provider, or experienced discrimination, stigma, or anticipated stigma during a healthcare visit (Zhang et al., 2020). These same factors can also inhibit certain sexual minorities from engaging in protective health behaviors (Emlet et al., 2017). In contrast, greater knowledge about patients' conditions promoted better communication with this marginalized population (Zhang et al., 2020).

Negative provider attitudes and behaviors, such as assumptions or judgments about sexual behaviors (Devarajan et al., 2019) or gender and romantic relationships (Pecanac et al., 2021), as well as gendered expectations about the "right" way for transgender patients to act (e.g., judging a transmasculine patient for painting his nails; See Kearns et al., 2021 for a review) can contribute to worse patient-provider relationships with LGBTQ+ individuals. However, providers can improve communication and relationships with LGBTQ+ individuals, especially transgender patients, by providing visual cues in offices that affirm sexual and gender identity (Pecanac et al., 2021), using proper pronoun etiquette (Lambrou et al., 2020), demonstrating knowledge about transgender healthcare and navigating transgender healthcare systems (Lambrou et al., 2020), including patients in healthcare decision-making (Pecanac et al., 2021), actively

listening to patients' discussions about their lives and desired medical trajectories (Lambrou et al., 2020; Pecanac et al., 2021), and using informed consent models that remove typical barriers to care experienced by transgender patients such as letters from mental health clinicians (Lambrou et al., 2020).

Cultural competence and humility

One way to create a more trusting patient-provider relationship is through increasing cultural competence and humility. The concept of cultural competence was developed within the field of social work in the early 1980s (Gallegos et al., 2008) and became widespread in the domains of medicine and public health soon after (Chong, 2002). Leininger's model of transcultural nursing care has remained salient in nursing and provided a framework grounding the concepts of culturally based care as essential in every nurse-client interaction (Petiprin, 2020). In the delivery of healthcare, cultural competence involves understanding how social and cultural factors influence patients' health beliefs and behaviors, considering interactions between these factors and various aspects of the healthcare system, and developing healthcare interventions with these interactions in mind (Betancourt et al., 2003). The construct offers an approach to caring for diverse patients, including racial and/or ethnic minorities and members of the LGBTQ+ community (Chong, 2002). Keiswetter and Brotemarkle (2010) suggest certified nursing leaders are well-positioned to model culturally competent practice for other staff and advocate for further education about TGNB patients and their needs.

As a framework to guide provider education and the delivery of health care, some criticize cultural competence for implying an endpoint in education exists when providers become "competent" in their knowledge and capacity to treat patients from specific backgrounds (Tervalon & Murray-García, 1998), as well as for utilizing a static definition of culture (Baker & Beagan, 2014). Baker and Beagan (2014) suggest an inaccurate conceptualization of culture hinders cross-cultural communication, as providers tend to perceive learned cultural stereotypes as "expertise" and identify patients' cultural backgrounds as "causing" health conditions. Critics of cultural competence suggest cultural humility as an alternative framework to guide care for diverse patients.

Cultural humility constitutes an approach to providing healthcare in which a provider commits to lifelong engagement in self-reflection and knowledge-building, gives weight to patients' knowledge about their own experiences and health, and remains open to identifying and addressing differences in power between themselves and a patient (Lekas et al., 2020). Cultural humility ameliorates the shortcomings of cultural competence by redressing patient-provider power dynamics (Tervalon & Murray-García, 1998) and emphasizing institution- and system-level factors that contribute to patient marginalization (Baker & Beagan, 2014). In their research on how shifting the paradigm away from cultural competence to cultural humility in Canada's healthcare system would benefit TGNB patients, Allwright et al. (2019) argue that cultural competence contributes

to the marginalization of LGBTQ+ patients. They also found that public health nurses could use cultural humility to cultivate "positive spaces" where environments, composed of services, programs, initiatives, and personnel, diminish the influence of hetero- and cisnormativity (e.g., conceptualizing the experiences of heterosexual and cisgender individuals as the norm; PFLAG, 2022) within healthcare systems (Allwright et al., 2019).

However, others such as Greene-Moton and Minkler (2019), suggest the idea of cultural humility cannot completely eclipse cultural competence. Instead, cultural competence and humility remain necessary for interactions with diverse patients. Danso (2018) argues that the concept of cultural competence incorporates aspects from the cultural humility approach such as "the need to question one's assumptions, beliefs, and biases" (p. 415). According to Greene-Moton and Minkler (2019), a both/and approach to cultural humility and cultural competence allows providers to continue learning about the communities they serve, with the understanding that such learning is lifelong and lacks a defined endpoint. This emphasis on lifelong learning also supports the concept of cultural humility as being especially applicable to nurses, as the continued professional development of nurses requires strategic planning and a lifelong commitment to learning.

Research about cultural humility in providing healthcare to sexual minority and TGNB patients indicates patients evaluate providers more on their authenticity and willingness to admit a lack of knowledge than their expertise about LGBTQ+ care (Baker & Beagan, 2014). Ruud (2018) utilized two case studies of a transgender male patient and a nonbinary patient to illustrate the complexity of issues related to providing healthcare to LGBTQ+ individuals. He suggested that providers who adopt a culturally humble approach are better equipped to serve members of gender and sexually diverse populations by, for example, not making appearance-based assumptions about patients' anatomies and sexual behaviors, and using inclusive language and patient forms (Ruud, 2018). Overall, research regarding the utility of cultural humility within LGBTQ+ healthcare suggests providers' assumptions can hinder patient-provider communication and relationships. However, the broader literature about the healthcare experiences of TGNB patients indicates patient-provider relationships could also be improved by increasing provider competence in the treatment of TGNB individuals, demonstrating the utility of the both/and approach suggested by Greene-Moton and Minkler (2019).

Current study

Previous research on the topic of provider interactions with TGNB patients has been conducted with adolescent (Kearns et al., 2021) and older adult samples (Cicero et al., 2019), leaving a dearth of knowledge about the healthcare experiences of TGNB young adults, who have specific health behaviors and needs such as access to gender-affirming hormone therapy (Bonnie et al., 2015; Eisenberg et al., 2020; Roberts & Fantz, 2014). Earlier studies in this domain have also conflated sexual and gender minority

populations (Pecanac et al., 2021), did not include gender minority participants (Devarajan et al., 2019), and only included the experiences of binary transgender patients (Lambrou et al., 2020). Given research with TGNB patients remains important for informing provider education and practice in caring for this population, questions remain regarding barriers to productive provider-patient communication and relationships and the roles of providers' cultural competence and humility. This study contributes to this gap in research by investigating: What factors facilitate and impede effective communication and relationships between TGNB young adults and their healthcare providers?

METHOD

Participants and procedure

Participants were recruited from the central Florida area (spanning Orlando, Tampa, Gainesville, and Jacksonville) through LGBTQ+ or transgender-specific community organizations, healthcare clinics and professionals, colleges and universities (via diversity offices, LGBTQ+ campus groups, or other LGBTQ+ campus services), and snowball sampling with other participants. The sample included 60 young adults (see Table 1 for demographic information) aged 18 to 24 ($M=20.81$, $SD=1.97$). Almost half the sample identified as transgender men ($n=26$, 43%), followed by nonbinary/gender non-conforming umbrella ($n=23$, 38%). Fewer participants identified as transgender women ($n=11$, 19%). Two participants (3%) were intersex. Participants were predominantly White ($n=45$, 75%), though a smaller portion identified as Hispanic or Latinx ($n=10$, 17%). While participants reported a variety of sexual identities, the most common sexual identity reported was bisexual ($n=17$, 28%). Additionally, more than half of the participants were undergraduate students ($n=39$, 65%) and received insurance through their parent(s) ($n=41$, 69%). The relatively large sample size ($n=60$) reflected the attempt to quota sample and help ensure equal representation across diverse gender identities (i.e., $n=20$ transgender men, $n=20$ transgender women, and $n=20$ nonbinary individuals). However, we were unable to reach our goal of recruiting 20 transgender women. Participant pseudonyms given in the results section were assigned by the first and fifth authors to reflect participants' gender identities.

Participants verbally consented to participate in the study and be audio recorded. Participants completed an individual interview with a White, nonbinary graduate research assistant, either in-person or over the telephone. Participants were compensated with a \$35 e-gift card code. All procedures were approved by the Institutional Review Board at the [university name].

Data collection

Individual interviews were conducted using an in-depth, semi-structured interview guide developed through reviewing relevant

TABLE 1 Demographic information.

	N (or M)	% (or SD)
Gender identity		
Transgender man ^a	26	43.0
Transgender woman	11	19.0
Gender non-conforming (GNC)	23	38.0
GNC	1	2.0
Genderqueer/fluid/flux	4	7.0
Nonbinary	17	28.0
Questioning	1	2.0
Age		
18–24	20.81	1.97
Sex identity		
Intersex	2	3.0
Endosex ^a	58	97.0
Sexuality		
Bisexual ^a	17	28.0
Queer/fluid	10	17.0
Gay/Lesbian	9	15.0
Asexual	9	15.0
Heterosexual	2	3.0
Questioning	2	3.0
Pansexual	11	19.0
Race/Ethnicity		
Hispanic/Latinx	10	17.0
White ^a	45	75.0
Asian	1	2.0
Black	1	2.0
Multiracial	3	5.0
Education Attainment		
No College	5	8.0
Some College	6	10.0
Undergraduate Student ^a	39	65.0
College Graduate	7	12.0
Graduate Student	3	5.0
Insurance status		
Parent's Insurance ^a	41	69.0
Employer-Sponsored	4	7.0
State-Funded	8	13.0
University-Sponsored	2	3.0
Uninsured	5	8.0

Note: All demographics are taken from the self-identification participants reported during the interviews, except for Sex Identity, in which the term "Endosex" was assigned by researchers when a participant did not indicate an intersex condition.

^aModal category for each demographic measure.

existing literature and discussion among a team of researchers. This guide featured open-ended questions about healthcare experiences, disclosure of gender identity to providers, experiences of stigma and

discrimination in healthcare settings, barriers and facilitators to receiving healthcare, desired qualities in healthcare providers, and desired improvements in healthcare for TGNB individuals. Prior to data collection, three transgender or nonbinary young adults pre-tested the interview guide. Interviews lasted 73 min, on average (range: 31 to 131 min). Audio recordings were transcribed verbatim by an independent, professional transcriptionist.

Coding procedures and data analysis

Two members of the research team conducted an initial round of coding on one of the transcripts, then met to discuss and generate a preliminary codebook rooted in thematic analysis and feminist fieldwork analysis, which interrogates the reproduction of social inequalities through a justice-oriented perspective (Kleinman, 2007). Using these frameworks as a basis, transcripts were then coded in NVivo 11 Plus (QSR International Pty Ltd, 2015) by the interviewer, two additional trained doctoral research assistants, and one trained medical student. The interviewer was broadly trained in qualitative research methods and received specific training in active interviewing (Holstein & Gubrium, 1995), and the doctoral RAs completed coursework in qualitative methods and were trained in analysis using qualitative software. Each transcript was only coded by one person, with the interviewer coding most transcripts ($n=35$). Coders were instructed to only code one transcript at a time. The final version of the codebook is available in Supplementary Table S1.

For the current analysis, the first two authors engaged in “focused coding” (Thornberg & Charmaz, 2014), where data coded within the original broad categories were re-analyzed to identify nuanced similarities and differences related to patient-provider relationships and communication. This analysis focused on themes associated with facilitators of and barriers to effective communication and relationships between providers and young TGNB patients, derived from codes such as “Provider Selection,” “Names and Pronouns,” “Barriers,” “Comfort or Discomfort,” “Coming out in Healthcare Settings,” “Facilitators,” and “Gender Inclusivity.” Saturation for the current analysis was reached during focused coding of the twentieth transcript, when no new themes related to this analysis were identified. This analysis resulted in identification of four themes (each described below), which were further assessed for their connections to cultural competence and humility.

RESULTS

We identified four main themes associated with improving communication and relationships between TGNB patients and their providers: (1) *Using patients' correct names and pronouns*, (2) *Following patients' leads*, (3) *Patients educating providers*, and (4) *Concerns about confidentiality*. The first two themes present procedures that facilitate productive patient-provider relationships, while the third and fourth themes address barriers to positive interactions. Within each

theme, participants offered recommendations associated with cultural competence and humility in their provision of healthcare. The themes are outlined below with emblematic quotes from participant interviews.

Using patients' correct names and pronouns

Many participants identified the importance of being addressed by their chosen names and pronouns, regardless of their legal identity or physical appearance. Participants also discussed the significance of being able to provide this information during a healthcare visit. In fact, many participants discussed how inclusive patient forms, with places to write one's chosen name and pronouns, indicated a provider or office was friendly to TGNB patients, which influenced their selection of providers and their level of comfort with a provider.

For example, when Terran, a transgender man who sought hysterectomy-related care related to his transition, was asked how reproductive healthcare providers could make their office spaces or practices more trans-friendly, he answered:

...I had to go to a women's clinic for all my hysterectomy stuff—just having more info for trans resources. Like at Planned Parenthood, they have a bunch of pamphlets and trans stuff, and they ask you “what are your pronouns?,” “what's your preferred name?,” stuff like that. It's so small, but it can make a place feel so much more inclusive.

When asked what made him feel “safe and comfortable” as a transgender man at a doctor's office, Jasper answered: “...when they have a section for ‘What is your preferred name?’ and ‘How do you identify?,’ it makes it a lot easier, because then I don't have to come out to every single doctor that I see.” In his answer to the same question, another transmasculine participant, River, explained the impact of intake forms on whether he remained in a doctor's office to receive care:

...And number one, if I'm filling out an intake form anywhere, and it's just sex—male or female—I'm out. Most of the time, I'll probably just walk out, because it's like, wait, like, yes? Both? I don't know. ...So, intake forms for me, especially if they have legal name, name used, pronouns, that to me is like, “Oh, here we go. We're golden.”

However, being able to give one's chosen name and pronouns to providers was virtually meaningless if the providers failed to incorporate that information into their interactions with patients. Terran described his experience of being misgendered and dead-named (i.e., when someone refers to the name a TGNB individual used at a different time in their life; PFLAG, 2022) during a visit to the emergency room, despite providing his correct name and pronouns to staff:

It's just so upsetting to have to deal with that, especially when the hospital asked me what my name was, what my pronouns were, how I identified. If they're going to ask you for that information, and then I'm going to have to deal with that, what's the point of asking?

When Jules, a transgender woman, was deadnamed and misgendered while seeking care at her university's health center, she viewed the experience as a reminder that "there's always danger present, and it's always appropriate to be anxious about it." She described the process of correcting others as "anxiety-inducing," even though it was "the right thing to do." London, a nonbinary participant, experienced a comparable situation when they sought psychological counseling through their university health center. Even though they provided their pronouns to the counselor through a form and discussion, the counselor struggled to refer to London correctly, which led to their breaking point:

...it was frustrating because a lot of what I was going to see her for was about me being trans and not being respected or understood. And then, ultimately, I was feeling bad, like suicidal—and we had a meeting, and she kept saying "she" about me, and I was like, "Are you kidding me? This is why I'm here. Even where I'm supposedly getting mental health [treatment]; you're the one making me want to kill myself? How is that OK?" So that was our last meeting.

Terran, Jules, and London's respective experiences seeking health-care illustrate that providing a place on forms for patients to share their chosen names and pronouns remains insufficient. To improve communication and relationships with TGNB patients, providers also must demonstrate cultural competence by asking about and consistently addressing them according to the information they provide about their identities.

Following patients' leads

Some participants discussed the need for providers to consider and accommodate potential dysphoria related to their genitals, indicating the utility of providers "following their lead" regarding words they use to describe their own anatomy, rather than using clinical language perceived as having "gendered" connotations.

Oakley, an agender participant, indicated that the way their OBGYN referred to their body was even more significant than using their correct pronouns:

[Providers] being receptive to requests about how I get to decide how my body is described is very important. I've heard this from other nonbinary people

as well—it's important that we get to decide what kind of language is used to describe our bodies. And I think that it's important for the healthcare setting, that they follow our lead in terms of how we describe and engage our body in the healthcare system.

...my pronouns are kind of important to me, but it's not a huge trigger for me if my pronouns are confused. But certain areas of my body that I do experience dysphoria about, it's very important to me and my mental health that they're not gendered. And I've had this discussion with [my] doctor, and it has been nice because she has been very receptive to using gender-neutral terms, so maybe saying "chest" instead of "breast" or just saying "genitals" instead of "vagina" or "penis" or whatever.

Oakley's emphasis on their OBGYN's "receptiveness" to using gender-neutral terminology for their body parts was echoed by another participant's attention to his provider's caution, respect, and humility regarding his anatomy. Jake, a transgender man, described his encounter with his OBGYN after he began his transition:

She just approached with such caution and asked me, "Do you feel uncomfortable with that region of your body?" She was able to ask me and respect any boundaries that I had, and she was just so comfortable with me that I was able to just like, "You know what? Let's just go for it. Let's do what we gotta do, and you made me so comfortable that I can do it."

When asked if there were any specific things providers should consider about better treating transgender and nonbinary patients, Jake responded:

...to know that dysphoria has its own range of things as well, and to know, "OK, well all right, I have a transgender patient coming in today"—I think the first thing they should talk about is, what are my boundaries? "Are there boundaries that you have that I need to know before I examine you?"

Similarly, Carmen, a nonbinary student, mentioned providers' sensitivity in their answer to the same question:

...definitely language and vocabulary around body parts. To be more sensitive and use different language with trans people, even if that means asking them what they want their body parts to be called. That seems like a good thing [laugh] for them to do, instead of just saying what they would say to a cis woman.

Jake and Carmen similarly mentioned the importance for health-care providers to prioritize inquiry-based communication with a

patient about their preferences and boundaries surrounding their own body, suggesting benefits of a “culturally humble” approach in which the doctor cedes to the patient’s expertise. River offered a similar approach for providers:

It’s being aware of how, when you’re talking with your clients, your patients, being aware of what they’re comfortable with, how they refer to their bodies. It can be simple. You can have them refer to their body. Somebody comes in and says, “Oh, I’m having whatever down there.” “Down where?” Right? Ask and let them explain to you and call whatever their issue they’re having however they refer to it so you know, and then you can just talk back again generally. You don’t have to refer to anything...you’ll be on the same page or whatever.

Or like I said, the way that my doctor did it—if the person is comfortable, because sometimes it can just be triggering regardless—just using anatomical body parts and dissociating them with the individual. So, we’re going to remove *the* uterus and then *the* yada yada. Removing gender from everything.

River’s idea that providers refer to patients’ issues and anatomy using patients’ own words resembles Oakley’s suggestion that providers “follow our [the patient’s] lead” in interactions with TGNB individuals. When taken together, the perceptions reflected by Oakley, Jake, Carmen, and River indicate the value of sensitivity and humility in patient-provider interactions, as well as the importance of focusing on patient comfort through open communication.

Patients educating providers

Participants also discussed the burden of educating their providers about their identities and needs as TGNB patients. Such experiences felt uncomfortable for participants and caused them to rush appointments and feel dissuaded from attempting to cultivate an effective relationship with their provider.

Cameron, a transgender man, described his encounters with nurses at his dentist office who he identified as having “conservative,” but not necessarily “ill-meaning,” ideas about gender and sexuality when they assumed he was a cisgender girl with a boyfriend.

Their default setting is not being aware of trans issues and gender non-conforming issues and things like that. So, when I go there, I want to talk as little as possible. I want minimum interaction. Because I don’t want to have to go through this in-depth conversation with you about what my identity means to me, and what it means in general. A lot of times, I will even have to explain what transgender means as a word because a lot of people are not familiar with it, and

it’s like—I just want to get my teeth cleaned and go. [laugh] So I just try to rush through the small talk.

In their interview, Drew, a nonbinary student, discussed feeling othered when correcting their provider about their gender:

It feels a little “objectifying.” [Maybe] that is not the right word, but it kind of makes you feel like you are an external factor from him. I’m like, we are all the same species—just this idea of humans—and the fact that I’m this outside thing to him is kind of bizarre. That was uncomfortable in the way that I did not want to be looked at in an external source. I was just like, “Well, it’s not that different than somebody being male.” It feels a little weird like ogled-wise, but at the same time, it’s one of those things where it’s like I would love to take the time and educate this man, but that’s not the time that we have in the world, while he’s like checking me for strep. It’s one of those things where I’m like, “I hope somebody eventually educates you. I just can’t be the one to do that right now.”

Though Drew had the willingness to educate their doctor, their priority was seeking care regarding their immediate health concerns. While the provider’s lack of competency in interactions with TGNB patients made the encounter “uncomfortable,” Drew did not perceive his deficit as their responsibility.

River echoed the idea that patients should not feel obligated to educate providers about TGNB identities. When he was asked whether coming out to providers had ever made them ask uncomfortable questions, River responded:

At the primary care that I was going to before the one I’m at now, every time I went, the people who did my intake—whether they were a nurse, MA, student, or whatnot—whomever I saw would almost always ask me something like, “Are you fully transitioned?” or something like that. I’m just like, “OK. So. Now I have to put on my work hat and educate you, even though I am paying you.” That’s just so frustrating to me. I want to be able to exist in my own life and not have to be at work all the time. I just think about how it shouldn’t be anyone’s obligation—anybody who identifies within the community—it shouldn’t be their obligation or prerogative to have to explain their identity to someone who they’re literally paying for a service from. [laugh] So, it’s just very discouraging.

Aside from causing discomfort and feelings of alienation un conducive to building positive patient-provider communication and relationships, some participants described the process of having to explain the concept of being transgender or gender non-conforming as a barrier

to disclosing their gender identity to their providers. Alex, a nonbinary, genderqueer participant, explained why they do not share their identity with doctors: "I'm afraid they won't understand, and it will just get awkward and annoying to explain how my gender identity isn't the same as my physical sex."

Other participants explained that educating providers lacking cultural competence about healthcare for TGNB patients felt disruptive to discussing their own healthcare concerns. Oakley, an agender participant, described the process of informing their provider about gender markers.

I had to kind of explain it and like, "Unfortunately, in Florida, you do not legally have an option to change it [the marker] to genderless, so you can leave it as just F. But it is important for you to know that if you're going to be using gendered language, you're going to be alienating me as your patient." So, I spent a lot of time educating him, and I think that's one of the difficult things that I have to do when I'm navigating healthcare with my doctor. I mean, I often have to derail conversations that we're having so that I can educate. Which would be great if he was maybe paying me for that. [laugh].

Cameron also stated that they did not come out to every provider, even when not doing so made them experience gender dysphoria, because they "don't always have the capacity mentally, emotionally, to ambassador for [their community] and don't feel obligated to have to tell everybody what [they] experience as a person." The participants' experiences discussed in this section illustrate the continued importance of provider competence, rather than humility alone, in the treatment of TGNB patients. Drew, River, and Oakley experienced inadequate provider knowledge as a distraction from their care and as a hindrance to productive communication and relationships with their providers.

Concerns about confidentiality

Several participants expressed concern regarding the confidentiality of the information collected by providers about their gender identities, especially in instances where the patient attended a practice in a small town. Participants indicated their fears that if they came out during an appointment, the provider would share this information with their parents, who they were not out to yet.

Jules, a transfeminine participant, believed that forms with her chosen name might make it back to her family: "...it's just the fear that some kind of paperwork could reach the hands of my family, which I'm not out to, and they would be confused and ask, 'Oh, who's Jules?' I just dread that scenario of being outed without my permission..." Because of this dread, Jules has not mentioned her gender identity to any of her providers, even though withholding

this information has begun to make her feel "dysphoric" when seeking healthcare.

Participants' concerns appear to stem from their distrust of physicians and function as a barrier or deterrent to disclosing information that may be helpful to their care. For instance, a nonbinary participant named Max discussed the challenges of not disclosing their identity to the provider in their small town:

...because of where I live and the doctors who I have, and the pool is so small that so many of my family go to the same doctors. And I know that it's a HIPAA violation to share patient stuff, but people don't really care about that here. [laugh] I feel there's a lot more skirting around the truth. And I wonder—certain diagnoses could potentially make more sense if I could just be more open. But it's just a conversation that can't be had.

While Max notes that HIPAA prohibits providers from sharing protected health information with individuals aside from the patient without their consent, they also indicate that these regulations are not always followed in practice. Max also mentions that being more open with their doctor could help them make sense of specific diagnoses they have received, but they are unable to do so out of fear, demonstrating that patient-provider communication and relationships are hindered by this lack of trust.

Cameron, a transgender man, also grew up in a small town and expressed the same sentiment regarding his parents finding out about his gender identity through his provider:

...in my hometown, I'm very much like the 'child of these parents,' and I think it would all route back to my parents, and they would be kind of given the authority almost...they would definitely be informed of everything, and that's not something I want them to be a part of. I want that to be my own issue and my own thing to deal with.

In their interview, London explained that the lack of trust they had in their provider was based on prior experience disclosing information unrelated to their identity:

Even when I've been over 18 and I've gone to the pediatrician and my mom has come with me...they have just unthinkingly turned and talked to my mom, even when I had specifically requested my mom leave the room so she wouldn't hear anything. And then when my mom would come back, they would just immediately start telling her what I had said. So, it was sort of like, 'I don't trust you to not say anything.' Even if I had specifically said, 'Don't tell my mom,' I wouldn't trust them to not tell my mom.

For some participants, the trust they demonstrated by disclosing their gender identities to their providers was violated, indicating that Max, Cameron, and London's fears were not unfounded. Reagan, a transmasculine participant, decided to come out to his pediatrician after he turned eighteen. He described his experience:

I was still seeing my pediatrician. And I had seen her at that point for over 11 years. I felt very comfortable with her. And I came out to her, and her immediate response was to then tell my father, and to suggest that I go and spend some time in a psych ward, which was so far out of what I would have expected from her, a doctor who I had really grown to trust and to feel comfortable with, over at that point the majority of my life. And that really kind of soured for me my willingness to come out.

According to Reagan, his experience with his pediatrician made him feel discouraged about coming out to other doctors, given that the doctor he had cultivated a relationship with for more than 11 years of his life betrayed his trust so easily. Thus, when seeking to improve communication and build relationships with TGNB young adult patients, providers must understand that competence in caring for this population encompasses maintaining the confidentiality of patient disclosures as well as educating them about their rights to medical privacy. Patient confidentiality is a particularly salient issue for TGNB young adults who continue to obtain healthcare from their pediatricians or the same family practice providers as their family members, even after reaching legal adulthood.

DISCUSSION

We sought to address gaps in the literature on provider communication with TGNB young adults by examining factors that facilitate and impede effective communication and relationships between TGNB individuals and healthcare providers. While the research in this article did not specifically measure TGNB persons' interactions with nurses, current literature on this topic suggests many of the findings from this study could be applicable to these interactions as well. Carabez et al. (2016) found that nurses often experience confusion regarding the correct pronouns to use for transgender patients, while Mikovits (2022) noted transgender persons perceived registered nurses as not possessing the necessary knowledge and understanding to provide care. Four themes emerged particularly relevant to enhancing provider communication and relationships with TGNB patients: using patients' correct names and pronouns, following patients' lead in terms of how they discuss their anatomy, patients having to educate their providers about TGNB healthcare, and patients' concerns regarding the confidentiality of identity-related disclosures.

Findings indicate that a "both/and" approach employing cultural competence and humility (as suggested by Greene-Moton &

Minkler, 2019) allows providers to address the specific needs of TGNB patients. The value of redressing the power dynamics between providers and patients, as offered by the concept of cultural humility, occurs when doctors request *and* use patients' chosen names and pronouns. Doing so positions the patient as the expert of their own identity rather than prioritizing the provider's perception, allowing TGNB patients to identify and present authentically, without being classified through the lens of the provider's biases, knowledge, and training. Research has supported the importance of this for nurses working with transgender persons as well. Mikovits (2022) found transgender persons felt more compassion and acceptance from nurses who used their chosen names and pronouns during care encounters. Our findings with young adults support research with adolescents (Eisenberg et al., 2020) that suggests correctly referring to TGNB patients creates an affirming environment and facilitates patient comfort and open communication essential to effective patient-provider relationships. When providers use language that shows respect for gender diversity, patients perceive healthcare encounters more positively (Baldwin et al., 2018; Mikovits, 2022).

Participants in the current study also recommended providers "follow the patient's lead" regarding how they refer to their anatomy to ameliorate inequitable power in patient-provider relationships. Affording patients an opportunity to share their language for their body parts gives them an active role in their representation. Additionally, following patients' leads prioritizes patients' knowledge and comfort over a provider's expertise, which can further facilitate patients' engagement in their own healthcare, thus enhancing patient outcomes (Vahdat et al., 2014). Our results are in line with findings from Klein and Golub (2020) study about enhancing gender-affirming provider communication. The transgender men and transmasculine nonbinary participants in their study wanted providers to ask directly for preferred language for their anatomy rather than making assumptions about the terminology to use. Some of our participants suggested the same. In Armuand et al. (2017) study of transgender men's experiences with fertility preservation, providers' use of "gender-specific" anatomical language, such as "vagina" and "uterus," distressed patients. Participants in our study also perceived certain clinical terms as having gendered connotations, sometimes leading to dysphoria.

Still, findings suggested transgender and nonbinary young adults expect providers to possess a minimum level of knowledge, or competence, regarding needs of TGNB patients. Participants did not want to educate their providers about transgender identities and healthcare. Providers' willingness to learn was unwelcome in the context of participants' office visits in which they were paying providers for care that was sometimes unrelated to their gender identities. Participants identified the task of answering invasive questions or explaining their gender identities as unpaid labor that disrupted the process of receiving care and reflected negatively on their providers. Thus, cultural humility without competence is not sufficient for enhancing patient-provider communication and relationships, as the "burden" of educating providers only served to "frustrate" and "discourage" our participants, potentially contributing to a

reluctance to seek further care. This finding supports research with transgender adults showing healthcare utilization is strongly associated with provider knowledge and the need for healthcare providers to become competent and maintain adequate knowledge to provide high-quality care to TGNB patients (Baldwin et al., 2018; Lerner et al., 2022; Mikovits, 2022; Poteat et al., 2013).

Nurses play an important role as patient advocates. Data indicate some transgender patients report no experiences in which a nurse acted as an advocate on their behalf (Mikovits, 2022). However, these same data also showed that transgender patients who did have experiences with nurses serving as their advocates, “lit up and were excited to share these stories” (Mikovits, 2022, p. 3020). This strengthens the assumption that transgender patients perceive nursing care as being better when the nurses caring for them serve as their advocates. Scholarly inquiries have also shown a relationship between organizational nursing quality indicators and organizational commitment to the care of LGBTQ+ individuals. For example, Blackwell (2019) found that healthcare organizations that achieved Magnet® status from the American Nurses Credentialing Center had higher levels of LGBTQ+-specific client services and support and commitment to LGBTQ+ equality. Healthcare organizations with Magnet® status must exhibit policies that indicate implementation of evidence-based care into practice (Blackwell, 2019). Blackwell (2019) asserted Magnet-recognized organizations with upper scores on the Healthcare Equality Index achieved these scores by implementing evidence-based care strategies to reach and/or preserve Magnet® status, including delivering culturally appropriate, LGBTQ+-specific, and high-quality care essential to the nursing profession's continued growth.

Additionally, our participants' narratives indicated that concerns regarding the disclosure of information related to their gender identities remain a barrier to building trusting and comfortable relationships with their providers. Research participants demonstrated that, especially in the context of small towns, existing regulations surrounding patient privacy are not enough to encourage identity disclosure; trust must also be earned. However, trust alone is also not enough, as illustrated by Reagan's experience with his life-long pediatrician outing him to his father. The results of our study support findings of research by Fisher et al. (2018) indicating transgender youth may not disclose their gender identity to their primary care providers due to fears of being “outed” to parents. Further, research by Pampati et al. (2019) with transgender youth indicated privacy concerns were a barrier to identity disclosure. Our findings add to this literature by illustrating the relevance of these concerns to TGNB young adults. Although young adults do not require parental consent for healthcare procedures, they still express concerns about their information being shared with parents.

Clinical relevance

Findings from the current study provide clear recommendations for providers and their staff. To facilitate trust and open communication

with TGNB patients, providers should ask for and consistently use patients' chosen pronouns and names. Likewise, all staff members, including assistants and front office staff, should be made aware of patients' names and trained in pronoun etiquette for consistency across the patients' experiences, as stigmatizing experiences in the waiting room can lead to less trust and communication in discussions with providers. Additionally, providers must find the balance between being culturally competent and humble. TGNB patients in the current study desired adequately trained providers with existing knowledge of their needs and do not want to educate providers while paying for their time. However, these patients also wanted providers to be humble enough to “follow their lead” in discussing patients' bodies and health issues by providers asking questions about which terms patients preferred, rather than making assumptions about terminology and patients' comfort. Thus, we recommend providers seek out training specific to TGNB patients, but also present opportunities for patients to remain engaged and provide input in their care.

Lim et al. (2015) found the median time devoted to teaching LGBTQ+-specific care content in Nursing B.S. programs was just 2.12 h, and nursing faculties believe they are underprepared and lack knowledge needed to teach these concepts (Carabez et al., 2016). Thus, a clear directive exists suggesting nursing curricula expand coverage focusing on the care of LGBTQ+ persons (McKay et al., 2022). Nursing faculties must seek out avenues of enhancing their knowledge on care of LGBTQ+ persons as well so they are better equipped to teach this content to future nurses. Currently practicing nurses, who have all committed to lifelong learning, can grow their expertise in caring for LGBTQ persons by seeking out continuing education activities focused on this competency. Finally, providers must appreciate that becoming competent in the care of TGNB individuals entails helping patients understand their rights to privacy and the boundaries of confidentiality, as well as preventing the disclosure of patient information, including to immediate family members. Providing culturally competent care to TGNB young adults through the protection of their privacy functions to create and maintain trust between patients and their providers, thus, facilitating productive communication and quality healthcare provision.

Strengths and limitations

The current study contributes to the literature by examining patient-provider communication and relationships with a relatively large sample of TGNB young adults. This contrasts with previous research that explored this topic with adolescent and older adult populations. Thus, our project helps to capture the unique needs of this specific population group. This project has the additional advantage of distinguishing between gender identity and sexual identity, rather than conflating the two as past studies have done. This advantage strengthened our findings by allowing the identification of factors related to gender identity specifically,

rather than issues experienced by both sexual and gender minorities. Furthermore, our sample had a high percentage (38%) of nonbinary participants, whereas other research has predominantly addressed the experiences of people with binary identities. This allowed us to gain insights into the needs of nonbinary individuals, which may differ from those of binary transgender individuals. Another strength offered by our study involved the depth and breadth of our interview questions regarding healthcare experiences and participants' identities (see Appendix S1). Such thorough questions allowed for the collection of in-depth qualitative data and enabled nuance and elaboration in participants' responses, in contrast to the limited variety of answers collected in survey research.

Despite these strengths, the current study does possess a few limitations. One limitation of the current study involves the focus on only patient perspectives, thus, only presenting one-half of the patient-provider relationship. Future research may benefit from interviewing patient-provider dyads, as provider perspectives may also illuminate factors that facilitate more effective patient-provider relationships (e.g., factors related to the clinic/hospital that patients might not be familiar with). In addition to the lack of provider perspectives, the current study was also limited by the sample being skewed in favor of transmasculine and nonbinary perspectives, whereas transfeminine patients were underrepresented. Transgender women and other transfeminine patients might have been able to provide additional recommendations for providers based on their unique experiences of transmisogyny (i.e., misogyny directed against transfeminine people that often manifests in the form of prejudice and bias; PFLAG, 2022), such as rigid expectations of performing femininity (Kearns et al., 2021). Another limitation is the lack of racial and ethnic diversity among the sample, limiting our knowledge of factors contributing to patient-provider relationships perceived by TGNB patients of color. Future studies should aim to analyze patient-provider relationships through an intersectional lens, as TGNB patients of color are likely more vulnerable to less effective patient-provider relationships and resulting disparities in health outcomes (see Asare et al., 2019; Lambrou et al., 2020 for examples). Additionally, about 70% of our participants were still insured through their parents or guardians. More perspectives from TGNB young adults without insurance are needed, as these individuals may have different limitations in their ability to seek out gender-affirming providers and may be able to provide additional insight into how providers can support their TGNB patients and have more effective patient-provider relationships and communication.

CONCLUSIONS

This qualitative research study provides an examination of patient-provider relationships with TGNB young adults from the patient perspective. The concepts of cultural competence and cultural humility can be used to guide clinical practice and facilitate positive

communication and productive relationships between providers and TGNB patients. When contextualized through the lens of cultural humility, the experiences of participants in this research study indicate that inequitable patient-provider power dynamics can be redressed by positioning the patient as the "expert" of their own identity and needs by referring to them correctly and "following their lead" in discussions regarding anatomy. Our findings regarding participants being required to educate their providers indicate the utility of establishing cultural competence in TGNB patient care. Further, our findings regarding participant concerns about privacy suggest that in the care of TGNB patients, cultural competence encompasses educating patients about their medical privacy rights and working to protect the confidentiality of any disclosed information. Thus, both cultural humility and competence are necessary for establishing equitable patient-provider relationships with TGNB patients. Finally, because nurses have the professional responsibility of serving as advocates for their patients, they must embrace the significance of equitable care for LGBTQ+ persons. Consequently, our study demonstrates the need for future research specifically focused on communication and relationships between nurses and TGNB patients.

CLINICAL RESOURCES

Center of Excellence for Transgender Health. Provides access to access to comprehensive, effective, and affirming healthcare services for transgender communities. <https://prevention.ucsf.edu/transhealth>.

Gay and Lesbian Medical Association. Educates both patients and providers about the unique healthcare needs of LGBTQ patients. <https://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=940&grandparentID=534&parentID=534>.

National LGBTQIA+ Health Education Center. Specializes in providing national training and technical assistance (T/TA) to health centers in order to optimize access to quality health care for LGBTQIA+ populations. <https://www.lgbtqihealtheducation.org/resources/in/transgender-health/>.

World Professional Association for Transgender Health. An international multidisciplinary professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health. <https://www.wpath.org/resources/general>.

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CONFLICT OF INTEREST STATEMENT

None of the authors have any conflicts of interest to disclose.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Table S1

Appendix S1.

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