



Documenting & Describing Experiences of Marginalized Gender Identities in Healthcare

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Abstract

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Keywords

healthcare, gender, health, health disparity, health disparities, cisgender, transgender, doctor-patient relationship, empathy, doctor-patient interaction, non-binary, medication, cardiac problems, women, andronormativity, patient-centered approach

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Abstract:

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One of the most significant aspects of a person's life is their health. When someone is in good health, they have the ability to experience life to its fullest, without the worry of feeling excessive pain or fatigue. Those who have lived in bad health know what it means to sit on the sidelines, worrying that if they live their lives despite their ill health, their bodies could betray them. This could have severe negative consequences on the individual's quality of life. To that end, "[t]he interaction between doctor and patient plays a crucial role in healthcare delivery," so it is important to understand the myriad of ways in which the doctor-patient relationship can fail or succeed in its mission to improve the patient's health and, therefore, life (Bertakis, 2009). However, the current gender disparity that exists within the U.S. healthcare system prevents many people with marginalized gender identities (i.e. women and non-gender conforming individuals) from feeling satisfied with the quality of their healthcare, while those whose gender identity is systematically privileged in society seem not to face the same struggles. This study aims to understand the ways in which people with marginalized gender identities experience healthcare through their interactions with healthcare professionals in healthcare settings.

Research Question

How is the doctor-patient relationship communicated to people with marginalized gender identities?

Literature Review

Sociodemographic Factors

In order to explore how healthcare professionals establish gendered differences to patients through their communication, the notion of 'gender' must first be defined. Gender itself "is a psychosocial construct determined by individuals' experience of being male or female, being largely learned through environmental and social cues" (Winter, 2015, p. 1). This means that a

person learns how to perform their gender through the environment or culture in which they are raised. Since most of Western culture has operated on a binary definition of gender, the most widely recognized genders in these cultures are ‘men’ and ‘women.’ However, gender identity has become much more culturally and noticeably recognized as fluid in recent years, and with this change comes resistance. It is essential to view gender and this research from an intersectional lens “as a way of understanding and analyzing the complexity in the world, in people, and in human experiences” (Collins & Bilge, 2016, p. 2). Collins & Bilge provide a working description of intersectionality, which is described below:

When it comes to social inequality, people’s lives and the organization of power in a given society are better understood as being shaped by not a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other (Collins & Bilge, 2016, p. 2).

One of the most important parts of this definition is that social power derives from “many axes that work together and influence each other,” because it highlights the true meaning of intersectionality and the myriad ways in which social power can be gained or taken away (Collins & Bilge, 2016, p. 2). According to this definition, it is unfair to assume that people of any marginalized identity experience difficulties in healthcare in the same ways. For example, a cisgender woman may be taken less seriously by her doctor, whereas a transgender woman faces the same difficulties in addition to hearing transphobic remarks from her healthcare professionals. In this example, cisgender, “can be used to describe individuals who possess, from birth into adulthood, the male or female reproductive organs (sex) typical of the social category of a man or woman (gender) to which that individual was assigned at birth” (Aultman, 2014, p. 61). Conversely, the term transgender means that “a transgender person’s gender is on the other

side (trans-) of their birth-assigned sex” (Aultman, 2014, p. 61). Du Pré writes that those with marginalized gender identities can receive substantially different treatment from healthcare professionals on the basis of their gender identity. According to this self-identified queer theorist, “[t]ransgender and intersex individuals face similar challenges... Negative reactions by health professionals can be especially hurtful for members of so-called gender minorities, for one, because they frequently face the pain of social censure and rejection” (Du Pré, 2017, p. 132). The idea of intersectionality also means that other sociodemographic factors can affect the doctor-patient interaction. For example, previous literature has identified unconscious biases in treatment of patients on the basis of race and sexual orientation. Garrick, et. al. (2018) found in a study that race plays a crucial role in the doctor-patient relationship. One of the study’s findings is that black doctors were more effective in getting their black patients to participate in preventative care, such as flu shots and “particularly for invasive exams” (Garrick O., et. al., 2018, p. 15). This has significant implications on the ways in which sociodemographic factors, like race and gender, have a profound effect on the communicatively constructed doctor-patient relationship, especially when someone has both a marginalized racial and gender identity.

In *Doing Harm*, Maya Dusenbery discusses what she calls “the trust gap,” which she states occurs between a doctor and a patient when “women’s accounts of their symptoms are too often not believed” (Dusenbery, 2018, p. 11). She writes, “[a]ll women – cis or trans – are affected by the trust gap,” whereas people who do not identify as women are not necessarily affected (Dusenbery, 2018, p. 13). Loikas explores this in a study, which reveals that “fewer women with coronary heart disease were found to be given appropriate medication” and “women with atrial fibrillation have been treated with anticoagulants to a lower extent than men” (Loikas, 2015, p. 8). The reason Dusenbery finds that doctors are more likely to treat women with these

unconscious biases, related to the history of women's mysterious symptoms, is "that women's complaints of pain are less likely to be trusted" (Dusenbery, 2018, p. 95). Samulowitz attempts to explain this disparity in treatment between men and women, citing gender norms as one of the potential reasons for this occurrence. Because gender norms are almost always unconsciously communicated in systemic functions, the existence of this disparity often goes unnoticed and unevaluated by those in health care settings. Samulowitz writes, "a variety of examples have been presented in which men and women have been treated differently for the same diseases, medically unmotivated, across a wide range of medical fields" (Samulowitz, 2017, p. 2).

At present, many organizations include training to address potential biases in physician behavior. However, research shows, "such training may fail to address unconscious racial stereotyping that affects provider behavior and decision-making" (Hye-cheon, 2015, p. 156). It is clear that something must change to address these systemic failures.

History of Gendered Differences in Healthcare

There is a long history of differences on the basis of gender, with a primary focus on cisgender women, since other gender identities have been marginalized to the point of erasure.

Campbell (1989) provides a framework for the ways in which women have been placed at a societal disadvantage from men. This inequality bleeds into every facet of life, including the healthcare system. Women have started out at such a disadvantage for so long that, "[a]s a result, when women began to speak outside the home on moral issues and on matters of public policy, they ... encountered profound resistance to their efforts for moral reform ... [b]ecause they were thought naturally incapable of reasoning, women were considered unsuited to engage in or to guide public deliberation" (Campbell, 1989, p. 10). These disadvantages have been ingrained into societal functioning for so long that, when women attempt to fight those disadvantages for

the first time, they are met with serious backlash that questions their ability to simply think for themselves.

More specifically, those working in the healthcare system have treated women differently since its early days. Dusenbery discusses the history of the word “hysteria” in healthcare, specifically used to describe women’s health issues. In early healthcare, many women’s issues, “from menstrual pain to dizziness to paralysis and mental symptoms,” have been attributed, “to the effects of a restless uterus roving about the body” (Dusenbery, 2018, p. 63). This shows that, since the early stages of healthcare, females and anyone with a uterus have been placed at a systematic disadvantage, since their health issues have been ignored and misdiagnosed. This has a profound impact on the quality of the interaction between doctors and their patients who are female.

Literature on Doctor-Patient Interaction

Much research has been done on the factors that influence the relationship between a doctor and their patient. One often overlooked aspect of this relationship is nonverbal communication. According to Hall’s (1995) work on nonverbal behavior in a medical setting, the exhibition of certain behaviors by a doctor can drastically improve a patient’s perceived relationship to them. Positive behaviors include, “attentive listening and not talking too much, avoiding excessive note taking and chart reading,” and “establishing eye contact” (Hall, 1995, p. 25). When doctors demonstrate these behaviors well to patients, the level of rapport in this relationship is increased. According to Hall, et. al., “[h]igh levels of rapport are characterized by: (a) high levels of mutual attentiveness or involvement, (b) high levels of positivity or warmth, and (c) high levels of behavioral coordination” (Hall, 1995, p. 27). Likewise, it is also important for the doctor to take notice of their patients’ nonverbal behaviors to ensure a trusting relationship.

Physician gender identity also has a significant impact on the quality of the doctor-patient interaction. According to Bertakis and Azari, “[f]emale physicians share more information, encourage patients to talk more, engage in more discussion of psychosocial topics, make more supportive statements, and emphasize partnership building and participatory decision making in their interactions with patients” (Bertakis & Azari, 2007, p. 860). Male physicians, however, “spend more time on medical history taking, structuring the interaction, planning treatment, and discussing its effects” (Bertakis & Azari, 2007, p. 860). Accordingly, female physicians tend to spend more time building a trusting relationship with their patients, whereas male physicians tend to focus on achieving the task at hand, which is to diagnose and treat their patients. Patients seem to be more satisfied with female physicians, “even after adjusting for patient characteristics and physician practice style,” which suggests that “patient satisfaction is influenced by physician gender, as well as physicians’ behavior” (Bertakis, 2009, p. 357).

While I conduct my research, it will be important to note that “gender is only one of many factors that influence physician-patient interaction” (Bertakis & Azari, 2007, p. 860). Other factors, such as, “specialty of the physician, length of the physician-patient relationship, patient health status, pain, depression, obesity, age, race, education, and income” will affect the patients’ perception of their healthcare experiences (Bertakis & Azari, 2007, p. 860). Clearly the nature of any doctor-patient relationship is dependent upon many factors. However, the previous literature exploring this relationship has failed to adequately analyze the individual interactions that occur between a person and their physician and what exactly those interactions look like in reality.

Bertakis’ study also found that a factor that may improve the doctor-patient relationship is a similarity in gender identity. It found that “gender-concordant visits exhibited higher scores on understanding the whole person compared with gender-discordant visits” (Bertakis, 2009, p.

358). In other words, when a doctor and their patient share similar gender identities, they both feel that they have a better understanding of each other than if they had differing gender identities. For example, a transgender female would feel that she has more in common with a doctor who was also a transgender female, rather than a doctor who was a cisgender male. This idea is also supported by Garrick, et. al.'s study on the connection between race and healthcare. Garrick, et. al. finds that black men "assigned to a black doctor increased their demand for preventives, particularly those which were invasive" (Garrick, et. al., 2018, p. 22). This implies that, when someone can identify with their doctor on a sociodemographic level, they are more likely to trust that doctor and follow their medical advice. Further, Garrick, et. al. found that "[t]hese findings were stronger among subjects who had high mistrust of the medical system as well as those who had limited prior experience with routine medical care" (Garrick, et. al., 2018, p. 22). When patients feel that their doctor is similar to them in some way, they feel more inclined to trust them. Unfortunately, since the overall population of doctors at present fails to represent the diversity as reflected in the U.S. population, it seems that there are likely to be mistrustful relationships between doctors and their patients.

According to a study done by Mazzi, et. al., gender did not appear to make much of a difference in "the quality of doctor-patient communication in gynaecological [sic] consultations" (Mazzi, et. al., p. 285, 2014). However, the two main differences noted were that "female doctors were criticized more than male doctors when they made impersonal comments and that female participants were more outspoken than men, positively and negatively" (Mazzi, et. al., 2014, p. 285). This indicates that females face differences in treatment even as the healthcare professional. It also demonstrates the idea that female patients feel the need to be more outspoken in their healthcare experiences, likely due to the differences in treatment related to

being less believed by their doctors. Mazzi mentioned, “a recent meta-analysis of studies reporting patients’ satisfaction with male and female doctors” showed a slight gendered difference in a patient’s satisfaction with their quality of healthcare (Mazzi, 2014, p. 294). Mazzi writes, “This might mean that for female doctors, ‘female behaviour’ – such as empathy, positive non-verbal behaviour and showing support and partnership – is expected. Therefore, it is taken for granted and not seen as part of their professional quality. Other research has also indicated this, with one study reporting that “female physicians may not receive appropriate credit in patients’ eyes for their patient-centered skills compared to their male counterparts” (Hall, 2015, p. 894). Since “[f]emale medical students and physicians excel over their male peers in communication skill and patient-centered style,” patients learn to expect this more patient-centered communication as the base level of care in female doctors (Hall, 2015, p. 895). But for male doctors, being empathic and emotionally oriented is seen as a bonus that fosters their professional skills” (Mazzi, et. al., 2014, p. 294). This more empathetic communication style is not an expectation for men, so when male doctors display this behavior, patient satisfaction is higher for the male doctor than their female counterparts. Hall writes, “Because of the overlap with patient-centeredness, it is likely that these behaviors when enacted by a female physician are assimilated to the female stereotype and result in patients seeing a ‘good woman’ (i.e., prototypical, behaving as expected) rather than a ‘good doctor.’ When enacted by a male physician, in contrast, these patient-centered behaviors do not fit the male stereotype, with the result that the behaviors are instead attributed to the physician being a ‘good doctor’” (Hall, 2015, p. 896).

Doctor-Patient Interaction with Non-Cisgender Female Patients

Much of the previous literature on gendered differences in the doctor-patient interaction focuses on cisgender males and cisgender females. While this research contains valuable data and information for this study, it is crucial that a wider scope of gender identities is studied. Too often in the field of healthcare, marginalized gender identities, such as transgender and non-binary, face harsher differences in treatment. This has a significant impact on the health of people with marginalized gender identities. This also applies to those whose sexual orientation differs from that of the stereotypical heterosexual norm. Paine (2018) writes, “[h]ealth and mortality outcomes among LGBTQ populations are also negatively impacted by exposure to stigma at the structural level in the forms of discriminatory policies and societal norms about gender, sex, and sexuality that define LGBTQ people as non-normative” (Paine, 2018, p. 352). In other words, LGBTQ populations are more likely to have a lower health status than their heterosexual, cisgender counterparts.

Transgender patients. While it is clear that women face negative differences in treatment in healthcare situations, a distinction must be made between cisgender women and transgender women, since the latter group often faces more discrimination and subsequent differences in treatment. Ross & Bell define transgender as, “an individual whose sense of self conflicts with the heteronormative binary that limits ways of being. Indeed, trans individuals traverse, bridge, and/or blur the boundaries of sex and gender by not conforming to the social expectations of the body they were born with because their inner conviction and mental image of the self does not match their body” (Ross & Bell, 2017, p. 730). As a result, transgender people face a type of treatment in healthcare that is unique only to them.

Ross & Bell found that transgender patients face negative differences in treatment of healthcare that differ from differences faced by cisgender female patients, including, “gender identity

insensitivity, clear verbal or nonverbal demonstrations of being uncomfortable, verbal abuse, denying patients healthcare services, less-than-quality care, verbal cruelty, and forcefully suggested actions for healthcare” (2017, p. 732).

Non-binary patients. Another group that faces discrimination and differences in treatment from their healthcare experiences is those who identify as non-binary. Paine (2018) defines nonbinary as a person who does not identify as either female or male. People who identify neither as female nor male can also identify as genderqueer or gender nonconforming. For the purposes of this study, the term nonbinary will be used to refer to those who do not identify as male or female. Marginalized gender identities may find solace in one another, since they all appear to face some sort of mistreatment in healthcare, but it is important to note that their identities and subsequent treatment differs. Paine writes, “nonbinary people, who identify as neither male nor female, report being misunderstood even in clinics designed to serve transgender populations” (Paine, 2018). Even spaces that are meant to accept people with a marginalized gender identity will not be perceived as fully accepting of all marginalized gender identities. Paine highlights the healthcare experiences of two nonbinary individuals, writing that neither felt like they were being taken seriously. Paine writes, “Corey felt uncertain about what aspects of his identity prompted ill-treatment after disruption, saying: ‘I think there are interactions where it's really difficult to tell what's affecting the treatment ... I don't know what problem you're having with me, but you're having a problem.’” (Paine, 2018, p. 356). The other (unnamed) non-binary person expressed feeling the same way in healthcare, although these two instances could also be due in part to their racial presentation. This shows the intersectionality of the issue in gendered differences in healthcare, as many other sociodemographic factors can contribute to this unsatisfactory treatment.

The Patient-Centered Approach

Perspectives of healthcare have changed considerably since the beginning of modern medicine, with a heavier focus on the patient's experience. Healthcare is evolving from a physician-centered to a patient-centered approach. The "patient-centered" approach to healthcare is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Wolfe, 2001, p. 6). In the past, more emphasis was placed on the physician's expertise in healthcare. With this new patient-centered approach, healthcare is now focusing more on the patient's knowledge and ensuring that the patient has ample "ability to secure appropriate and preferred medical assistance when and where it is needed" (Berry, 2003, p. 568). This means that patients are being listened to more, therefore creating the ability for the patient to provide the framework for their own health outcomes, rather than negating their story by giving a heavier focus to merely physical symptoms.

Methods

This research focuses on the experiences of people with marginalized gender identities and their relationships with their physicians and other healthcare professionals. Because of this focus on the patients' perception of quality of care, this research uses focus groups, a qualitative method, as its primary source of data retrieval.

Because of all the strict laws regarding privacy of patients' information, any direct observation of these differences would be a violation of patient trust and further violate the trust that should be felt in a healthcare setting.

This study's goal was to understand the ways in which people with marginalized gender identities are treated in conversations with their physicians and other healthcare professionals in

healthcare facilities. The nature of this study, then, requires that qualitative methods of data retrieval were used, as they are more relevant to the data-gathering process. Qualitative methods are interested in “how signifying [meaning] occurs and what it means for those who engage in it” (Lindlof, 1995, p. 22). Quantitative methods, on the other hand, “have been insufficient to perform those tasks – not because these modes of inquiry are faulty, but because they advocate views of the world that do not value the study of situated, emergent, and reflexive human phenomena” (Lindlof, 1995, p. 22). Quantitative methods of inquiry fail to account for the fluid meanings that constitute people’s lives, while qualitative inquiry succeeds in understanding the importance of individual meaning. Because of this, quantitative methods are insufficient to conduct this study effectively.

For the purpose of this research, focus groups were the primary method used to gather data. These focus groups focused on women’s experiences in more intimate and personal settings of the healthcare systems, such as examination rooms of primary care facilities.

Differences in healthcare on the basis of gender is a topic that is not typically in the forefront of people’s minds, meaning people who experience any negative treatment in healthcare may not have explicitly thought about the reason for this treatment. Focus groups, then, allowed participants to communicate openly about this topic to make sense of their experiences in a constructive manner (Morgan & Krueger, 1993). Kitzinger writes that focus groups are especially beneficial for “exploring people’s knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way” (Kitzinger, 1995, p. 299). Through these focus groups, participants were able to make sense of their negative experiences in healthcare with a group of people who could empathize with their situations. It was also able to help them recognize harmful experiences that they were unaware of at the time

it happened, since “group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview” (Kitzinger, 1995, p. 299).

Kitzinger also writes that the history of focus groups is rooted in health and health education, stating that they help “examine people’s experiences of disease and of health services” (Kitzinger, 1995, p. 299).

It is important to the goal of this research that the participants of these focus groups felt that their voices and criticisms of the healthcare system are heard, which is another reason why focus groups are the most beneficial. I wanted the participants to lead the conversation into directions they feel are relevant to their experiences, which is why I prepared “a series of open ended questions” in order to “encourage research participants to explore the issues of importance to them, in their own vocabulary, generating their own questions and pursuing their own priorities” (Kitzinger, 1995, p. 299). According to Kreps and Thornton, “people tell stories to recount and account for their experiences, using narratives to organize and share with others their personal versions of social reality” (Kreps & Thornton, 1992, p. 36). By allowing them to share their experiences openly, participants were able to construct their own narratives and show others the aspects of healthcare that matter most to them, especially in the doctor-patient interaction.

Another often overlooked advantage of focus groups is that they “[d]o not discriminate against people who cannot read or write” (Kitzinger, 1995, p. 300). While this can be considered a broader advantage of the use of focus groups in any research, it is also important to note for this study, since literacy is a factor that is presumed in many health contexts, particularly when a doctor is discussing treatment methods with their patients.

I recorded and transcribed the data I collected from my focus groups. While recording a person may cause them to act unnaturally, I did not consider it an issue for this phase of research,

since the social nature of the focus group will help participants feel more at ease and free to act more naturally. In total, I conducted two focus groups, each consisting of three participants. Originally, I planned to conduct three focus groups with anywhere from three to ten participants. However, the limitations of my research included the availability of people willing to participate in my research. Given that much of this research was conducted in the midst of a pandemic, I found myself unable to complete the third focus group in time. Technology could have allowed the focus group to be conducted via a video call; however, video calls are not conducive to environments that require trust and openness to thrive. Given that prior research demonstrates differences in treatment of male and female patients, the purpose of my focus groups will be to explore the experiences of those who feel their experiences with healthcare professionals are inadequate. Because of this, my focus group will consist solely of people who identify as something other than a cisgender man. This includes cisgender women, transgender women, transgender men, non-binary people, and any other unnamed gender identities.

The recruitment process was vital in determining the collection of relevant data. The aim of the study is to seek out how people with marginalized gender identities of all backgrounds feel about their quality of care in healthcare facilities, so I reflected this in the participants I recruit. Two of the most important factors I accounted for were age and race, as both could contribute to differences in healthcare treatment, and this study aims to see how gender alone affects the discrepancy. To ensure that I recruited participants of a diverse set of ages and races, I needed to think about where to recruit participants.

The best way to do this would be to post flyers where many different people go, like a convenience store or gas station. I posted flyers with the information about the focus groups with

an email address for interested participants to message. I screened volunteers for appropriate categories, such as race, age, and gender.

For the purpose of this study, moderator involvement in focus groups was generally low, and the focus groups were less structured. This type of focus group is “especially useful for exploratory research,” as it “provide[s] the opportunity to hear the interests of the participants themselves in each group” (Morgan, 1997). Therefore, the research questions acted merely as a guide to the conversation, but the participants were truly in control of the topics discussed. Specific focus group questions are listed below.

- Write a word that describes your quality of care when receiving treatment (like at a doctor’s office) – Why did you write this word?
- Think of a time when you felt like your doctor or healthcare provider was either understanding you perfectly OR when you feel like they weren’t taking you seriously/not listening to you. Write it down and describe your experience.
- Tell a story of a time where you felt either that the healthcare system was successful in treating you OR a time when it failed you.
- Describe your favorite doctor you’ve had and why you like them.

The focus groups will be recorded and transcribed, then the first round of coding will begin. I will first use in vivo coding, which “uses words or short phrases from the participants’ own language” to extract meaning (Miles & Huberman, 2014). I will then use descriptive coding to “[assign] labels to data to summarize in a word or phrase” (Miles & Huberman, 2014). This will help me develop my findings more as I get into the next step of coding, which Esterberg talks about in *Qualitative Methods in Social Research*. I would go through my data line by line again, using focused coding to focus on themes “identified during open coding” (Esterberg, 2002).

Findings

After careful analysis of the data, the most prominent findings that emerged are the language used by the participants regarding their experiences in healthcare. There was a notable difference in language used between positive and negative experiences in one's healthcare, which directly shows ways in which healthcare providers can improve a patient's perception of their healthcare. Participants also noted the importance of advocates attending their healthcare appointments. Metacommunicative language has been instrumental in creating therapeutic relationships, which is defined as, "the characteristics of information exchange between therapist and patient that facilitate a mutually gratifying relationship between participants so as to accomplish the goal of reduced morbidity for the patient" (Kreps & Thornton, 1992, p. 47). Research has found "metacommunicative transactions to be repeatedly useful in addressing therapeutic impasses or points at which the therapeutic relationship has felt difficult or strained" (Widdowson, 2008. p. 65). In other words, metacommunicative language is one of the best ways in which we can begin to change the aspects of relationships that do not serve the therapeutic purpose. Therefore, the metacommunicative language used by the participants should be analyzed to begin the process needed to transform these doctor-patient relationships for the better. For the sake of anonymity, names of all participants have been changed.

Positive Experiences

Participants of the focus group used more collaborative language to describe the nature of their positive encounters with healthcare providers. This means that the participants used verbs and phrases that indicated a trusting, open and communicative relationship between themselves and their doctor during the appointment. In other words, both the doctor and the patient felt comfortable enough to speak openly to each other while knowing that they have established trust

between them. It has become clear through this data that trust is an important factor in the patients perception of their healthcare experience.

For instance, Alex, a transgender male, said:

She [doctor] was just fantastic, too because - the last time I saw her was before I started transitioning, and I told her I'm looking into transitioning, you know, I'm a trans guy, and I was really nervous talking about that, because sometimes doctors don't understand that... but she was super **supportive**, and she was like, 'oh, let's **talk about** what birth control **options** would be best for you.' And she was like, 'I don't think this should interact with anything, like the hormones you're taking or anything,' and she was extremely **supportive**.

Most notably, Alex uses the word “supportive” twice in his description of a positive encounter with a healthcare provider. Additionally, use of the term “let’s talk about” has significant implications on a patient’s expectations and hopes for their conversation and impending relationship with their healthcare provider. The term implies that a level of trust and mutual respect must be or already be built between the patient and provider. In other words, not only does the patient respect the healthcare provider’s professional power and medical knowledge, but the healthcare provider also recognizes the patient’s autonomy and knowledge of their own selves. It supports a patient-centered approach to medicine, rather than a practitioner-centered approach.

Another interesting theme emerging from the data, due in part to this excerpt, is the importance of options to a patient’s perception of their healthcare experience. For example, Alex specifically uses the word “options” in reference to his doctor discussing birth control methods with him. Rather than assuming that she knew what was best for her patient, Alex’s doctor made

him an active member of the decision-making process. This is another demonstration of mutual trust and respect for a patient by the healthcare provider, and it also shows how healthcare providers can ensure that their patients feel more positively about their encounters with healthcare in the future.

Molly, a cisgender woman, also brings up the importance of trust in a doctor-patient relationship, particularly when communicating with her OB-GYN:

I first thought of my OB-GYN doctor, because - I don't know, I feel like that's the only place I go to and I know I'm gonna get good care. I feel like I have a **good relationship** with her. I've never had regular periods, so I feel like I've always struggled with finding a good birth control, or figuring out how to make that normal. And so, I finally went and had a good **conversation** with my OB-GYN, like, a year ago, and figured out what pill is gonna work for me and - I don't know, I felt like she **really listened** to me and she knew what was gonna do that for me. I - no one ever allowed me to go on normal birth control because of my history with migraines, and so, she was like, 'well, **I think that you can handle it,**' and she just let me go on it and it's been fine since, and I just felt grateful that she just didn't dismiss me when I said that I wanted to do that.

The first implication of the importance of collaboration in a doctor-patient relationship comes with the word "conversation." This word implies that two parties will be coming together, simultaneously sending and delivering messages to each other. In the context of healthcare, it implies that the doctor shares with the patient what they feel is important, but the patient does the same with the doctor. Molly says that her OB-GYN "really listened," which is another important

aspect of their interaction. Listening is an important part of the healthcare experience for the patient, as evidenced in this example.

Additionally, themes of the doctor-patient relationship emerge. Molly mentions that she knows she has a “good relationship” with her OB-GYN, and this is, at least in part, the reason she feels her healthcare experience was successful in this instance.

An interesting aspect of this example is when Molly is asking about her birth control options in regard to her “history with migraines,” to which the OB-GYN responds, “well, I think you can handle it.” This is significant because it implies a level of trust in the patient. Molly implied that previous doctors have dismissed her when discussing “normal” birth control options, which may have left her feeling like she does not have knowledge of or power over her own body. Overall, it appears from this example that a trusting relationship with one’s doctor is important in determining the quality of healthcare.

Additionally, Amelia, a cisgender woman, frames her positive experiences in healthcare around the negative experiences she has had:

I would say my therapist back home is my favorite person ever...I go in there and it’s like - people say ‘judgement-free’ and like, ‘oh, I’m not judging you,’ but sometimes you get a weird vibe, and I’ve had a lot of really bad experiences with that...but with her, I knew from the get-go that she was really **listening** to me and **hearing** me. I was able to really open up quickly with her and really get done what I needed to get done, and we were successful.

In this example, lack of judgement is an important factor in determining the quality of healthcare. Later, Amelia goes on to describe some of the “bad experiences” she has faced in healthcare, which will be discussed later. However, in this example, she mentions a lack of

judgement as being important in determining her favorite doctor. For many people, healthcare, especially for mental health, can be surrounded by a lot of stigma, so it is important to know that the doctor is doing their job effectively (and correctly) by refraining from injecting personal beliefs into the appointment.

Another important aspect tied to judgement is listening. Mentioned in Molly's example, listening is an aspect of the doctor-patient relationship that implies care and trust in the patient. If a doctor deemed a patient untrustworthy, they may ignore what the patient is saying and regard only symptoms they can visibly detect. However, by listening to a patient, they are not only obtaining more useful information about them and their potential health concerns, but they are also ensuring the patient's own well-being and comfort in the appointment itself.

Other examples of collaborative terms used in positive experiences include "explain," "get to know," "rapport," "walked me through," "remembers," and "acknowledge." Figure 1 (appendix 6) shows all of the language used to describe participants' positive experiences in healthcare.

Negative Experiences

Opposite to collaborative verbs being used in positive experiences, participants used more one-sided terms when discussing their negative experiences in healthcare. This means that, instead of words that foster a two-sided conversation between a doctor and patient, participants use terms like "told," "yelling," and "dismissing." Examples of all terms used in negative experiences can be found in the appendix.

Molly, a cisgender woman, recounts a negative experience with an endocrinologist for her hypothyroidism:

And the first time I ever went to this specialist I see, and now I just see my family doctor for it, she was just very upfront and **she just started telling me everything I'm doing wrong**, and basically it wasn't a conversation...she's, like, explaining it to me, but also just being like, 'you don't eat healthy, you need to cut this, this, and this out of your diet... your triglycerides are through the roof and blah blah blah,' and I'm like, 'what does that even mean?' I was maybe 16, 17, so I was just sitting there like, "okay, so...what?" And then she basically goes, 'are you anorexic?' And I was like... 'no, I-I think I eat food, like - I don't have an issue in that area, but, like, why are you yelling at me? I just found out I had this issue, like a week ago. It was just very aggressive and I was - like, from that point on, she kind of calmed down, and I think she - I was on the **verge of tears**, and I think she realized and kind of pulled back, but at first, it was just like a - I don't know. It was just really uncomfortable... [i]t was bad. I didn't enjoy it.

Interestingly, Molly described the absence of a conversation as one of the reasons why her experience was negative. This shows why collaboration is important to the healthcare experience, since the absence of conversation seems to negatively affect patient perception. Another aspect of Molly mentions that made her experience negative is that her healthcare provider made negative assumptions about her on the basis of her age. When Molly said, "she just started telling me everything I'm doing wrong," it is evident that this creates an unwelcoming space for the patient to exist. Trust is clearly essential in creating an environment in which the patient can thrive. When unconscious biases like these are allowed to be part of the healthcare interaction, the physician becomes the most important person in the healthcare interaction, and the patient's needs are not as important. When trust is not built between a patient and a healthcare professional, any attempt at a collaborative action becomes invasive and

aggressive. Molly proves this when she talks about the questions her healthcare provider asks her, which only exacerbates the aggressive atmosphere during the appointment. As a result, Molly is on “the verge of tears” during her appointment, and her experience became unenjoyable. Although healthcare experiences are not always expected to be pleasant or comfortable, it is clear that Molly’s unenjoyable experience stems from her relationship, or lack thereof, with her doctor.

The second example of a negative healthcare experience comes from Sydney, who recounts a time when her doctor was dismissive of her chest pain:

[The nurse] was like, “**well, what do you mean by chest pain?**”...and she was like, “well, there’s nothing wrong with you, like, it’s - **you’re not having a heart attack,**” or something, and I was like, “okay, well, thank you for that!” But then, she was asking me, “what medication are you on?” And I was like, “well, I’m on the pill.” And she’s like, “which one,” and I’m like, “well, I don’t remember the name,” ‘cause they give me a different generic one every time. And she was like, “well, you should know this stuff, like, if you’re going to school,” ‘cause I think she thought that I was a freshman, and my mom was like, “no, she’s going *back* to school.” She was like, “well, I don’t know how you haven’t figured this out by then.” And then my mom was like, “you know she spent, like, a year in France abroad by herself?” And she goes, “**I don’t know how she did that.**”

Throughout her retelling of her negative experience, Sydney assumes an accusatory tone whenever she replicates what her nurse said to her. In question like, “what do you mean by chest pain?” it is possible that this could be an empathetic response to Sydney’s symptoms. However, the meaning changes when the nurse’s delivery is more accusatory. Clearly, a statement like,

“well, you’re not having a heart attack,” is not helpful to Sydney’s worries, as evidenced by her response to it. The nurse also says she doesn’t “know how” Sydney was able to spend time abroad, implying a lack of trust in her as a patient and negatively impacting her healthcare experience. Overall, Sydney describes her nurse’s comments as unhelpful to her, which creates a negative environment for her and makes the possibility of her receiving quality care less likely. Additionally, Sydney says that this nurse “was older, she was probably in her fifties, and I think she just thought I was young and dumb or something.” Even if the nurse did not actually believe that her patient was “young and dumb,” like Sydney mentioned, it is still relevant that the patient believes this is how her nurse feels about her. It is imperative that the patient feels that their healthcare provider respects them, so trust can be built and a relationship can be established. After all of these negative comments, Sydney says, “but she was also kind of yelling at me that my mom was there. She was like, ‘Aren’t you old enough?’” Sydney perceived her healthcare provider as “yelling” at her for having an advocate during her appointment. This is wrong, not only because her nurse appeared to be angry with her, but also because she is insinuating that advocates are unnecessary in some health contexts. Health advocacy is an important part of healthcare and should not be diminished, especially not by healthcare workers themselves. These are a few instances in which participants used negative language when describing their negative healthcare experiences. Figure 2 shows a frequency table of all words and phrases used by the participants to describe their negative experiences in healthcare. They can be found in appendix 7.

Interestingly, when comparing both Figure 1 and Figure 2, participants tended to use language with more positive connotations when discussing their positive healthcare experiences. When discussing negative experiences, however, participants tended to use words or phrases with

neither a positive nor a negative connotation, like in the words “say” and “tell.” This may indicate that the participants felt that, in their negative healthcare experiences, their doctors did not care to create a welcoming environment; instead, the doctors focused on the cold, factual aspects of the interaction, which led to the participants reflecting this in their discussion.

When talking about what their healthcare providers did not do, they tended to use more positive language with words like “conversation” and “comfort.” For example, during their ultrasound for a gallbladder issue, Charlie, who identifies as nonbinary, says, “I don’t remember ever feeling comforted by the ultrasound lady.” In this case, Charlie does not mention what their healthcare provider did that made the experience negative. Instead, they say what the ultrasound technician failed to do - in this case, comfort someone who feels “scared” at the idea of getting their gallbladder removed.

Discussion

Qualitative and quantitative methods of inquiry often provide each other with complementary needs. Whereas quantitative methods can often provide the generalizability of findings, qualitative methods allow those same findings to be explored on a much deeper level through individual stories and experiences. The purpose of this research, then, is to provide the depth of data that has not yet been documented. According to my research, people with these gender identities have been marginalized in healthcare, both in experience and in much of the mainstream research on healthcare itself.

Although it is impossible to know the roots of the issues in healthcare we see in this data, these findings support the idea that gender, among other potential factors, influence patient perception and health outcomes. Additionally, the research in the literature review support the

idea that gender is a driving force in differences in healthcare. Loikas' studies on women's issues in healthcare show that women have been marginalized to some extent in their healthcare experiences, and my findings explore this relationship further through the language they use.

Language is one of the primary ways in which we are able to communicate our experiences to each other. The metacommunicative language used by participants in this study reveal how they perceive their experiences in healthcare. Even if their experiences differ slightly from the reality of the experience, their perception is still vital to understanding the experiences of people with marginalized gender identities in healthcare. By looking further into their perceptions of their experiences, the world of healthcare can learn more about how to change their own methods of empathy, trust, and listening in order to improve patient health outcomes.

Empathy can be demonstrated by "accurately stating and acknowledging the other's feelings in interpersonal interaction," which includes "nodding one's head," "maintaining eye contact," and asking "mirror questions and reflective probes" that help the patient feel understood by their doctor (Kreps & Thornton, 1992, p. 49). Trust can be built through "empathetic behaviors, but also through behaviors that increase vulnerability to another person" (Kreps & Thornton, 1992, p. 49). In a healthcare context, this may mean that doctors share some of their own health experiences to minimize the stigma surrounding certain areas of healthcare, or simply by reminding the patient that their health experiences are valid. With both empathy and trust come listening, another integral part of health communication. Effective listening behaviors include, "reflective feedback... asking questions, making statements and by offering visual cues that indicate whether or not you have understood what is being said" (Kreps & Thornton, 1992, p. 53). By demonstrating all of these behaviors in health settings, healthcare professionals will be able to mitigate the discrepancies in quality of healthcare on the basis of one's gender.

Conclusion

Much of this research was conducted at the time of the COVID-19 pandemic. As a result of this health crisis, many people are taking a deeper look into the U.S. healthcare system. Often, the results are disappointing, as the U.S. is notorious for its underwhelming policies regarding health. For example, the Pew Research Center states, “the U.S is the only country among 41 nations that does not mandate any paid leave for new parents” (Livingston & Thomas, 2019). Additionally, the pandemic shows that sick leave is not implemented in every job in the U.S. Pew Research Center cites that roughly 33.6 million people working in the U.S. do not have access to paid sick leave. That’s 24% of the U.S. working population, but the numbers worsen once you sort workers by income (Desilver, 2020). Access to quality healthcare is an intersectional issue, and it is becoming clearer to the U.S. population that changes need to be made to allow everyone the quality of care they should be receiving. For this reason, this research can be used to guide doctor-patient interactions that can allow better outcomes for both parties.

There are limitations to this study. The participants for the focus groups were selected in a small community, so there could be a difference in language used if a larger, more comprehensive study were conducted. Additionally, this study could be strengthened if more focus groups were conducted and the analysis of the focus group transcripts were conducted by a larger group. However, this study is meant to serve as a starting point to spark more interest in this topic and, subsequently, encourage more research.

Improving the doctor-patient relationship can help the patient have a more positive perception of their own healthcare experiences. However, it is also beneficial for the doctor to spend more time

on their relationship with their patients, since it can help patients be more open about sharing their symptoms with their doctor and potentially creating better health outcomes.

These findings show that changes need to be made in order to reduce the negative experiences many people face in healthcare. Currently, much of the training in the healthcare system does not address the unconscious biases that affect patient perception and quality of care. Since these biases are ingrained into U.S. society's functioning, anyone who participates in this society is perpetuating the biases on some level. This means that those who benefit from their privileges, like cisgender men, support the stereotypes of gendered individuals. However, it also means that those who are marginalized by these stereotypes are also perpetuating them by continuing to support the society that discriminates against them. This means that everyone can improve their communication to address their unconscious biases and improve health outcomes for all. One way our healthcare providers can change this is by being more empathetic with patients. By taking more time to establish a strong and meaningful relationship with their patients, healthcare providers can ensure that their patients can have a better quality of care. Implementing a program that demonstrates a more empathic approach could help providers become more emotionally literate and improve their interpersonal skills when communicating with patients.

One of the most valued aspects of the patient's healthcare experience based on my findings is the ability to have a good relationship with their doctor. This relationship can improve when the doctor demonstrates trust, listening, and empathy when interacting with their patients. Empathy is cited as one of the primary ways to reduce provider bias, as it can, "increase provider confidence and decrease anxiety and uncertainty that can lead to poor patient-provider interactions" (Hye-cheon, 2015, p. 156-157). Additionally, healthcare providers can become more aware of their own unconscious biases that cause them to treat patients differently over

things the patients cannot control. There are countless resources that describe the unconscious biases that every individual has at some point, as well as ways to minimize the negative impact those biases have on ourselves and others. By placing a heavier emphasis on empathy, doctors can provide their patients with better care. By using these findings to influence the doctor-patient relationship, we can begin to look at the changes that need to be made in healthcare to minimize the number of negative experiences for everyone, regardless of their gender.

Appendix

1. Focus Group Questions

- Write a word that describes your quality of care when receiving treatment (like at a doctor's office) – Why did you write this word?
- Think of a time when you felt like your doctor or healthcare provider was either understanding you perfectly OR when you feel like they weren't taking you seriously/not listening to you. Write it down and describe your experience.
- Tell a story of a time where you felt either that the healthcare system was successful in treating you OR a time when it failed you.
- Describe your favorite doctor you've had and why you like them.

2. Figure 1: Positive Experiences

Word/Phrase	Frequency
Talk to/about	3
Listen	3
Explain	2
Talk/walk me through	2
Conversation	2
Get to know me	1
Rapport	1
Thorough	1
Understand	1
Point	1
Hear	1
Remember	1
Acknowledge	1

3. Figure 2: Negative Experiences

Word/Phrase	Frequency
Say	7
Tell	4
Yell	2
Conversation (didn't)	2
Comfort (didn't)	2
Talk	2
Ask (didn't)	1
Get in touch (didn't)	1
Dismiss	1
Know (didn't)	1
Look into	1
Understand (didn't)	1
Attentive (didn't)	1
Keep in the loop (didn't)	1
Address	1

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