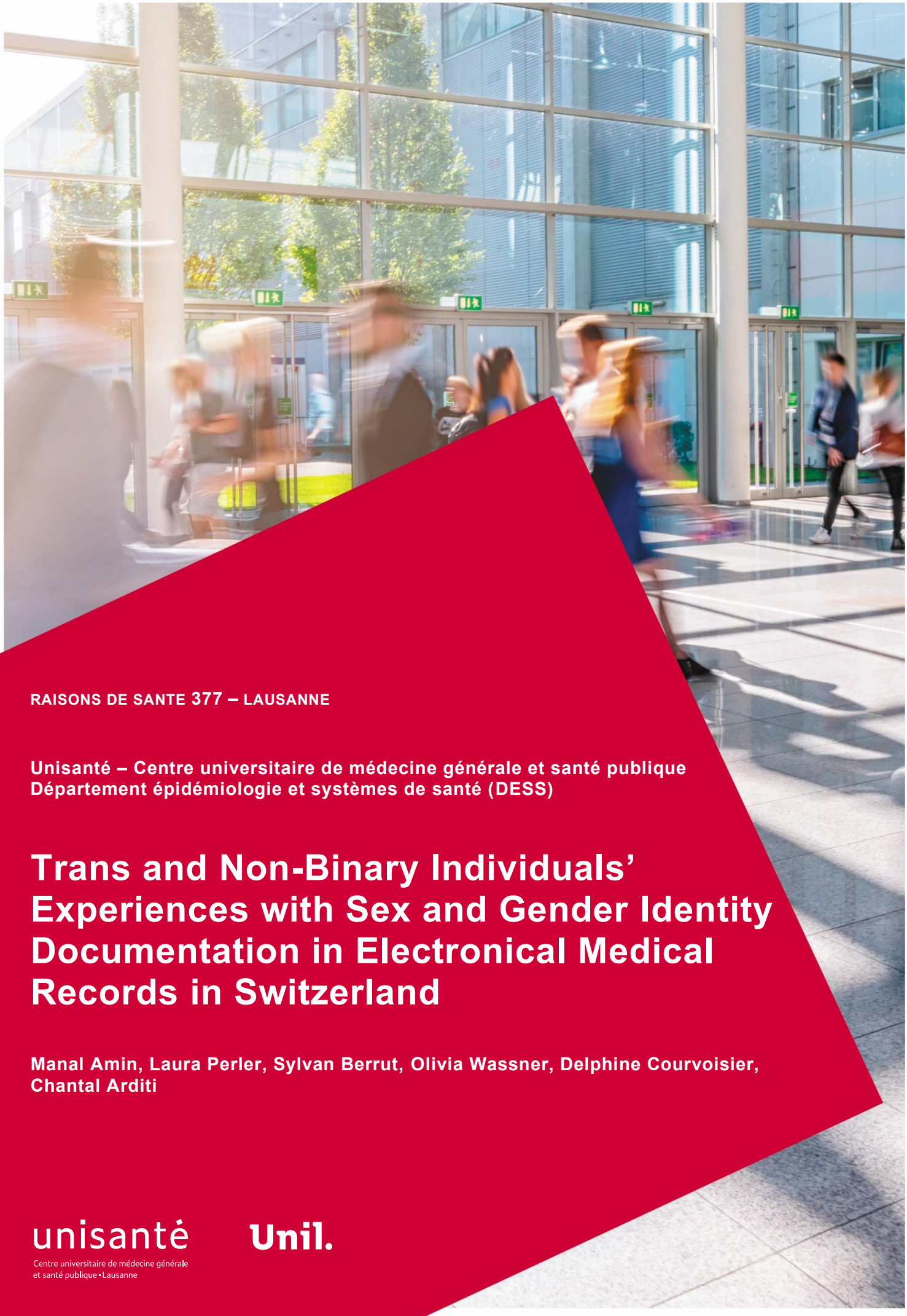

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Unisanté – Centre universitaire de médecine générale et santé publique
Département épidémiologie et systèmes de santé (DESS)

Trans and Non-Binary Individuals' Experiences with Sex and Gender Identity Documentation in Electronical Medical Records in Switzerland

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Abstract

Problem

The absence of inclusive and comprehensive sex and gender identity documentation in electronic medical records (EMRs) represents a major structural barrier to equitable healthcare access for trans and non-binary (TNB) individuals in Switzerland. Despite the significance of this issue, empirical data on the lived experiences of TNB individuals remain limited.

Methods

This cross-sectional study aimed to describe the experiences of TNB individuals regarding documentation of and communication about sex and gender identity, at the structural, interpersonal and individual levels, as well as self-reported healthcare avoidance. Data were collected with an online survey assessing structural factors (documentation accuracy, form inclusivity, ease of data modification, provider knowledge), interpersonal factors (respectful communication, perceived rejection, breach of confidentiality, medical harm) and individual-level factors (disclosure safety, disclosure of gender identity, negative expectations, non-disclosure behavior), and healthcare avoidance.

Analyses were conducted by gender identity (woman, man, non-binary, multiple – grouping individuals who selected more than one gender identity) and by healthcare setting (primary care, specialized care, emergency care, inpatient care, and mental health care).

Results

Analyses of the answers from 156 participants revealed significant heterogeneity in experiences based on both patient's gender identity and healthcare setting. Specifically, non-binary and multiple gender individuals reported experiencing significantly more adverse events, including misgendering, the use of incorrect sex/gender attributes, and encountering non-inclusive data collection processes.

Furthermore, differences were observed across settings and professional roles: adverse experiences were reported less frequently in gender clinics and mental health settings compared to non-gender clinics and emergency departments. Significant knowledge gaps among healthcare providers regarding TNB health were identified, particularly among general practitioners and emergency department physicians, while psychologists received notably higher ratings.

In total, 41% of participants delayed or avoided care due to fear of discrimination—nearly twice the rate reported in US data and six times higher than the general Swiss population.

Conclusion

Results highlight systemic challenges requiring multi-level structural interventions: reforms to health information systems, targeted provider training, and enhanced patient control over identity data. These findings will inform the development of evidence-based recommendations to improve the documentation of sex and gender identity in medical records in Switzerland.

Résumé

Problématique

L'absence de documentation inclusive et exhaustive du sexe et de l'identité de genre dans les dossiers médicaux électroniques (DME) constitue une barrière structurelle majeure à l'accès équitable aux soins de santé pour les personnes trans et non-binaires (TNB) en Suisse. Malgré l'importance de cette problématique, les données empiriques sur les expériences vécues par les individus TNB demeurent limitées.

Méthode

Cette étude transversale visait à décrire les expériences des personnes TNB concernant la documentation et la communication autour du sexe et de l'identité de genre, aux niveaux structurel, interpersonnel et individuel, ainsi que le renoncement aux soins auto-rapporté. Les données ont été recueillies au moyen d'une enquête en ligne portant sur les facteurs structurels (exactitude de la documentation, inclusivité des formulaires, facilité de modification des données connaissances des prestataires), les facteurs interpersonnels (communication respectueuse, rejet perçu, violation de la confidentialité, préjudice médical), les facteurs individuels (sécurité perçue de la divulgation, divulgation de l'identité de de genre, attentes négatives, comportement de non-divulgation), et le renoncement aux soins.

Les données ont été analysées par identité de genre (femme, homme, non-binaire, multiple – regroupant les personnes ayant coché plus d'une identité de genre) et par contexte de soins (soins primaires, soins spécialisés, soins d'urgence, soins stationnaires, et soins en santé mentale).

Résultats

L'analyse des réponses des 156 participant·exs a révélé une hétérogénéité significative des expériences en fonction à la fois de l'identité de genre des patient·es et du contexte de soins. Plus précisément, les personnes non binaires et de genre divers ont rapporté significativement davantage d'expériences négatives, notamment des situations de mégenrage, l'utilisation d'attributs de sexe ou de genre incorrects, ainsi que des processus de collecte de données non inclusifs.

Des différences ont été observées selon les contextes de soins et les rôles professionnels : les expériences défavorables étaient moins fréquemment rapportées dans les cliniques spécialisées en genre et en santé mentale que dans les services non spécialisés et les services d'urgence. D'importantes lacunes de connaissances concernant la santé des personnes TNB ont été identifiées parmi les professionnel·lexs de santé, en particulier chez les médecins généralistes et les

médecins des services d'urgence, tandis que les psychologues ont obtenu des évaluations nettement plus positives.

Au total, 41% des participant·exs avaient retardé ou évité les soins par crainte de discrimination, un taux presque deux fois supérieur aux données américaines et six fois plus élevé que dans la population générale suisse.

Conclusion

Les résultats mettent en évidence des défis systémiques qui exigent des interventions structurelles à plusieurs niveaux : réformes des systèmes d'information en santé, formation ciblée des prestataires et mécanismes de contrôle accru par les patient·exs sur leurs données d'identité. Ces résultats contribueront à l'élaboration de recommandations fondées sur des données probantes pour améliorer la documentation du sexe et l'identité de genre dans les dossiers médicaux en Suisse.

1 Introduction

1.1 The problem

Medical documentation systems processing paper-based or electronic medical records, such as admission forms or medical reports, typically offer a binary male or female option for the administrative gender attribute, poorly accounting for alternatives, while offering generally only one option for first name. This is often problematic for trans and/or non-binary individuals, who may find it difficult to answer these questions: What should be indicated? The sex on the insurance card, the sex assigned at birth, or the gender identity? The official or the chosen name? It can also lead to very uncomfortable situations for TNB individuals and healthcare professionals, such as the use of the wrong first name and/or gender (e.g., A trans women called « Mister Müller!" in the waiting room), misunderstandings, or even to delayed care or problems in care provision, such as assumptions as to the organs present or other physical characteristics on the basis of sex/gender indication (e.g., fetotoxic treatment in a potentially pregnant trans man), sex-differentiated scales for certain tests and analyses (e.g., presence of a prostate on MRI of a trans woman).

However, it is crucial to also recognize that gender identity is sensitive personal information and that collecting information on sex/gender can also be a source of vulnerability for patients, particularly in terms of confidentiality, the security of sensitive data and the risk of unintended disclosure [1, 2]. Indeed, the ability to identify a person as trans and/or non-binary (e.g., knowing that their gender identity differs from the sex assigned at birth) can pose a risk of discrimination and violence. These concerns are heightened by the heterogeneous and often inadequate implementation of gender identity data fields in EMRs, along with a lack of standardized data collection practices[3-6]. Therefore, proposed solutions must carefully balance the benefits of collecting more detailed data with the imperative to protect individuals. This issue requires mechanisms that enable individuals to withhold or disclose specific information selectively, or to limit its disclosure, according to their preferences[7].

As of January 1, 2022, Switzerland has standardized and simplified the procedure for official gender changes. Trans individuals can have their official gender and first name changed by making a declaration, without requiring medical treatment. Consequently, the number of individuals whose official gender and first name do not align with their biological sex characteristics is expected to increase, leading healthcare institutions to deal manage a growing number of patients in these situations.

1.2 Previous research

The language used by medical institutions, including the terminology for recording sex and gender in electronic medical records (EMR), plays a crucial role in in enhancing inclusivity and reducing misgendering. Indeed, language can "serve to further marginalize trans people"[8] and contribute to structural stigma, defined as "intentional and unintentional policies and practices that result in

restricted opportunities for stigmatized people"[9]. For example, a study examining the experiences of TNB individuals with current EMR documentation[10] found that the misuse of names, pronouns, or gender marker was common, leading to eroded trust and trauma for TNB individuals. A Swiss clinical team has also highlighted ongoing discriminations against lesbian, gay, bisexual, transgender, queer, intersex, asexual and other identities (LGBTQIA+) people in a Swiss emergency department[11]. Previous studies have documented the challenges of capturing accurate sex and gender information in medical records and the frequency of misgendering[12-17], underscoring the need for more comprehensive and sensitive approaches to capturing and integrating sex and gender identity data in healthcare records to ensure equitable and inclusive care for TNB people It is recognized that "sex as well as gender is relevant and both are often required information in a medical setting"[8]. A patient's biological sex characteristics can affect differential diagnoses and investigations of a clinical presentation, population-based screening recommendations and the normal values for laboratory testing, while gender identity is critical for communicating with the patient in a respectful manner.

The inadequate collection of sex/gender-related data, combined with insufficient specialized knowledge among HCPs, can severely compromise the quality of care for TNB and intersex individuals. This deficiency leads to significant challenges in interpreting laboratory tests, including chemistry and hematological analyses, which can be affected by hormone therapy and gender-affirming medical interventions[18]. Furthermore, inaccurate gender/sex identification in medical records impedes the provision of appropriate care and treatment, potentially resulting in misdiagnosis and delayed interventions[19]. This issue extends to laboratory pathology tests, where a lack of TNB-specific reference ranges and interpretation guidelines can lead to misinterpretations[20, 21]. Relying solely on assigned sex at birth (ASAB) within clinical settings and EMRs can also be a significant source of risk for TNB and intersex patients. This oversimplification can lead to the misinterpretation of clinical data, such as blood analyses and medical imaging, as biological norms are assumed based on a single parameter[20, 22]. Furthermore, it can result in suboptimal treatment, maltreatment, or even an outright lack of access to certain medical options when a provider's assumptions about a patient's body do not align with their actual needs[23]. Moreover, TNB individuals face unique challenges with medical hardware devices such as radiological devices and their software, which are often designed with binary assumptions, further highlighting the systemic neglect of their specific healthcare needs[22].

1.3 The GENDER-REACH project

In response to these challenges, the GENDER-REACH project, funded by the Swiss National Science Foundation in the context of the National Research Program 83 'Gender Medicine and Health' (Project 226943: Improving sex and gender documentation in Swiss medical records for REspectful and Accessible Care and Health for trans and non-binary people (GENDER-REACH)) aims to improve sex- and gender-related documentation practices in Swiss healthcare. The project has four main objectives:

1. to review current practices, opinions, needs and preferences concerning sex, gender identity, and associated attributes (i.e., official and chosen first name(s), honorifics,

pronoun(s)) used in electronic medical and health records (EMRs & EHRs), abroad and in Switzerland, based on a rapid literature review, online surveys, key informant interviews, and focus groups with TNB and intersex individuals as well as healthcare professionals;

2. to select evidence-based and expert-validated attributes concerning sex, gender identity, and associated attributes with a standardized nomenclature (e.g., attribute name or identifier, definition, answers) through a Delphi consensus process;

3. to pilot test the feasibility, usability, and acceptability of these attributes among both patients and healthcare professionals of these attributes, in two healthcare institutions; and

4. to develop and disseminate a national guideline on the recommended attributes and their appropriate use, informed by the pilot results and the consensus of a stakeholder advisory group.

The overarching objective of the project is to achieve sex- and gender-inclusive forms and data management that allow individuals to record information about their sex and gender in a way that reflects their own situations, experiences, identities and preferences, and to develop recommendations for medical documentation that reflect an understanding of the biological and social dimensions of sex/gender.

1.4 Objectives of this study

This study addressed part of the first objective of the GENDER-REACH project presented above. More specifically, it aimed to:

1. describe the experiences of TNB and intersex (TNBI) individuals with current sex/gender documentation and communication practices in Swiss healthcare settings;

2. assess the extent of healthcare avoidance or delay among TNBI individuals; and

3. identify TNBI individuals' main preferences and suggestions for more inclusive medical documentation and communication practices in Swiss healthcare settings.

2 Methods

2.1 Research Design

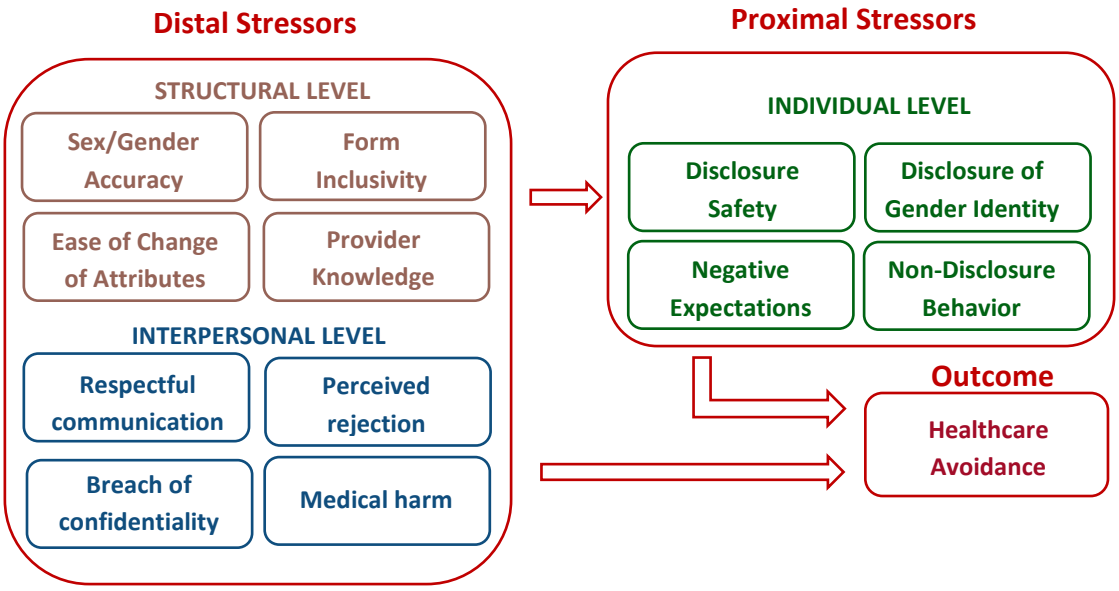
This study used a cross-sectional survey design.

2.2 Theoretical framework

We developed our theoretical framework based on three concepts and models. First, we used the concept of stigma, as articulated by Link and Phelan[24], which centers on the convergence of labeling, stereotyping, separation, status loss, and discrimination within a context of power imbalance. Their model underscores that stigma is not merely a matter of individual attitudes but a complex social process that leads to the marginalization of particular groups. It highlights how these components interact to create and perpetuate disadvantages, emphasizing that the presence of power differentials is essential for stigma to operate. Second, we used the Gender Minority Stress and Resilience (GMSR) model, which focuses specifically on the experiences of trans and gender non-conforming individuals [25]. This model posits that distal stressors negatively impact psychological well-being. These effects are mediated by proximal stressors which arise from the distal stressors. The model also incorporates resilience factors, acknowledging that individual strengths can buffer the impact of these stressors. This model offers a nuanced understanding of the unique stressors faced by gender minority populations and the protective role of resilience. Third, Velasco[26, 27] tailor the concept of stigma to the specific context of trans and gender-diverse individuals accessing healthcare. Their research, employing concept analysis and qualitative meta-synthesis, reveals that stigma in this context manifests at individual, interpersonal, and structural socio-ecological levels.

In the context of improving TNB inclusive data collection processes, these concepts converge to illuminate the potential for stigmatization within healthcare systems, modelized in Figure 1. Specifically, inadequate data collection processes can not only become a site of stigmatization, contributing to experiences of rejection, victimization, and non-affirmation, but also negatively influence the patient-healthcare professional communication and relationship. This can further increase the power imbalance between patient and healthcare professional, decrease the trust necessary to disclose sensitive sex/gender-related data, and erode trust in the healthcare treatment itself, ultimately leading to delays in seeking necessary medical care. By applying the frameworks of Link and Phelan, Testa et al., and Velasco, we seek to understand how systemic limitations in data collection contribute to healthcare avoidance, hindering their access to equitable healthcare.

Figure 1 Theoretical framework



2.3 Population and Recruitment

The target population included individuals who identify as trans and/or non-binary individuals, as well as intersex individuals who often face similar structural and interpersonal challenges in healthcare, who were 14 years old and older.

Participants were recruited using a convenience and snowball sampling approach to effectively reach a diverse and often hard-to-access population that is not easily captured through traditional probability sampling. The online survey link, available in English, German, and French, was distributed through various channels, including community organizations for TNB people, healthcare providers, universities, and research institutes. Recruitment for the study was conducted in two waves over a period of nearly two months, from July 10, 2025, to September 4, 2025 through a mixed-mode approach using both digital and physical flyers in English, French, and German. No compensation was offered for participation in the survey, which took approximately 20 to 35 minutes to complete, depending on the number of healthcare settings a participant had used and was willing to provide information on.

In the first wave, flyers were distributed online and in person. In total, 11 organizations of medical professionals and 22 LGBTIQ+ community organizations were contacted via email and asked to share the survey link. The survey was also disseminated through 11 dedicated online forums and chats for transgender individuals. Additionally, printed flyers were placed in different gender clinics across Switzerland, and networks of medical professionals specializing in trans healthcare were asked to share the flyers within their clinics. A second wave of recruitment consisted of an Instagram campaign launched in collaboration with Unisanté and TGNS. Other organizations were also asked to share the campaign to broaden its reach. This multi-pronged strategy was designed to ensure a wide and diverse recruitment of participants from the target population.

2.4 Data collection

2.4.1 Data Collection Mode

An online survey was created and administered using REDcap (Research Electronic Data Capture), a secure, web-based application hosted by Unisanté in Lausanne. Once participants gave informed consent, they completed the questionnaire in a logical sequence, in a design chosen to minimize participant burden and ensure data relevance by tailoring questions to their personal experiences.

1. *Screening and transition information:* The first section collected data on participants' sex/gender identity, as well as their transition status.
2. *Healthcare use and setting-specific experiences:* Participants were asked to report their use of care within the last 12 months in five healthcare settings: 1) primary care, 2) specialized care (e.g., endocrinologist, gynecologist, urologist), 3) emergency care, 4) inpatient care, 5) mental health care (e.g., psychologist, psychiatrist). They were then instructed to select maximum two settings in which they had experiences within the last 12 months. For each of these settings, they were asked to detail their experiences.
3. *General experiences in healthcare:* Following the setting-specific questions, the survey shifted to general questions about experiences. This included questions about delaying or avoiding needed healthcare, reasons for delaying care, and instances of medical harm in the last 12 months, as well as two free-text questions about positive and negative experiences
4. *Preferences and suggestions*: the next section asked participants about their preferences for the collection of and access to sex/gender information, and what would make healthcare more inclusive.
5. *Gender-Minority Stress and Resilience (GMSR) and other measures*: this section included three scales from the GMSR measures (negative expectations, internalized transphobia, non-disclosure behavior) as well as a question on passing, a scale on perceived social support[28], and the Brief COPE scale on coping strategies [29].
6. *Demographics and health:* The final section of the survey collected demographic information and subjective health data.

2.4.2 Questionnaire Development and Translation

The selection and adaptation of questions to be included in the questionnaire were grounded in our theoretical framework depicted in Figure 1.

For the structural level, the questionnaire included items measuring: (a) sex/gender accuracy, (b) form inclusivity, (c) the ease of change of sex/gender attributes, and (d) patient perceptions of providers' knowledge regarding the social, communication, mental, and physical aspects of TNB and intersex healthcare. **On the interpersonal level**, the survey addressed the interactions between patients and healthcare professionals. It included the following subthemes: (a) respectful communication, (b) perceived rejection, (c) breaches of confidentiality, and (d) medical harm, all

within the context of oral communication related to EMRs. All these scales except medical harm were presented within the context of different healthcare settings. **On the individual level**, the questionnaire measured: (a) perception of disclosure safety, (b) disclosure of gender identity to social groups, (c) internalized transphobia, (d) negative expectations, (e) non-disclosure behavior, (f) perceived social support, and (g) coping strategies. Items of the scales (c) – (e) were adapted from the proximal stressors of the GMSRM to fit the healthcare context. Due to the limited applicability of the GMSRM's proximal resources in a healthcare setting, these were substituted with the measures proposed by She et al[30].

The questionnaire was available in English, German, and French. For validated scales, existing validated translations were used whenever possible. In cases where a validated translation was unavailable, questions were translated using DeepL.com and then checked by a native speaker on the research team to ensure accuracy. The complete questionnaire was then pretested with 2 to 3 users for each language. During this phase, participants were interviewed using a guide to collect detailed feedback. Detailed notes were taken during these interviews, and the feedback was subsequently discussed within the research team to refine the final questionnaire.

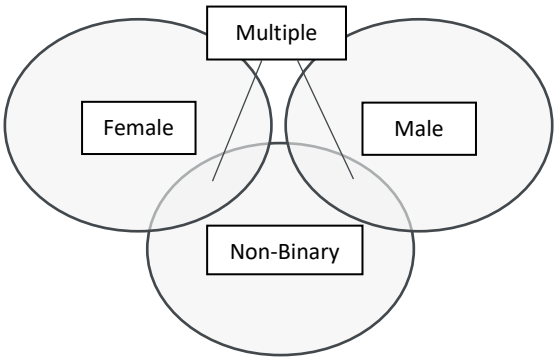
2.4.3 Questions and Scales

Sex/gender-related Data and Medical Transition State

Participants were asked about their **gender identity**, with the option to select multiple identities from categories including 'woman/feminine', 'man/masculine', 'non-binary', and 'not listed here, namely:' (i.e., other). This measure was included to capture the diversity of gender identities among participants, which is crucial for understanding differential experiences of stigmatization in healthcare settings[24, 31].

For the purpose of the analysis, these responses were recategorized into four distinct, mutually exclusive groups: female, male, non-binary (including gender fluid and agender), and multiple (defined as selecting a binary and a non-binary gender identity), depicted in Figure 2.

Figure 2 Classification of Gender Identities



We included one question on **assigned sex at birth (ASAB)**, where the participants had the options to select male, female, or other; one question on **legal gender** (female, male, other); and one

question on whether the person had requested a **change to their legal gender** (yes, no, prefer not to say).

A multi-step approach was used to assess **medical transition status**. Participants were first asked if they had undergone or planned to undergo any gender-affirming medical steps. If they had, a subsequent question asked if they had undergone or planned to undergo any medical steps to reverse or undo these gender-affirming steps

Socio-demographic Characteristics and Overall Health

To protect participant anonymity, a restricted set of demographic characteristics was chosen, with broad categories were used, based on those impacting healthcare-seeking behavior[32]. These characteristics included **age in categories** (14-17, 18-24, 25-44, 45-65, 65+ years), **financial strain** (had trouble paying household bills in the last 12 months: yes or no[33]) and **highest education level** (compulsory - primary school, lower secondary school, upper secondary - apprenticeship, baccalaureate, and tertiary education - bachelor's, master's, or doctoral degree). Additionally, the **country** where participants had primarily lived during the last 12 months was collected to verify that the data pertains to experiences within the Swiss healthcare system. The provided options included Switzerland, a neighboring country, and a free-text field for other countries.

Subjective health was assessed with the question, "How would you rate your overall health in the last 12 months?" Participants could choose from a 5-point scale with options ranging from poor to excellent[34].

Variables on the Structural Level

The correct use of sex/gender attributes in written communication (**sex/gender accuracy**) assessed how frequently the participant's honorifics, used name, pronouns, and gender identity were correctly used in the healthcare provider's digital communications, specifically in (e-)mail correspondence and forms on their webpage or smartphone apps. The four-item scale demonstrated strong internal reliability across the various healthcare settings (Cronbach's α ranging from 0.87 to 0.95).

A key aspect of our instrument was the measure of **form inclusivity**, defined as the extent to which paper or electronic forms are designed to be inclusive of a full range of sex and gender identities relevant to EMR documentation. To assess this, participants were asked to evaluate the forms they encountered in a healthcare setting based on how inclusively questions and options were provided for a wide range of attributes (n=10). The specific attributes assessed included honorifics, used name, pronouns, gender identity, variation in sex characteristics, legal gender, ASAB, hormonal state, organ inventory, and state of medical (de-)transition. A strong internal reliability ranging between $\alpha = 0.77$ to $\alpha = 0.99$ was achieved for the various healthcare settings.

To evaluate the **ease of change of attributes**, the participants were asked: "How easy or difficult was it to change the following information?" using a 5-point Likert scale ranging from 'Impossible' to 'Very easy'. This scale specifically focused on the flexibility of the EMR system's administrative process for key identity information, including honorifics, used name, pronouns, gender identity,

and legal gender. The internal reliability for this five-item scale, measured across the various healthcare settings, was found to be strong, ranging from α = 0.79 to α= 0.86.

Four distinct scales were developed to assess patient perceptions of their **healthcare providers' knowledge** relevant to TNB individuals. For all subsequent scales on provider knowledge, a 5-point Likert scale was used, where a value of 1 represented the lowest level of perceived knowledge (e.g., "Not informed at all") and a value of 5 the highest (e.g., "Very well informed"). The overall scale value for multi-item scales was calculated by taking the average of the scores from all questions.

1. The two-item scale on provider **knowledge of social aspects** was designed to assess patient perceptions of their healthcare providers' understanding of the social challenges faced by (de-) trans, non-binary, and intersex individuals (DTNBIs). For each healthcare setting (e.g., primary care, specialized care), participants were asked: 1) "How informed was the [HCP] about challenges at work or school as well as in the family related to (de-)transitioning?", and 2) "Did the [HCP] actions suggest an awareness of how sex/gender stereotyping can affect TNB patients seeking care?" The response options ranged from 'Not at all aware' to 'Extremely aware'. The internal reliability for this scale, measured across the various healthcare settings, was found to be strong, ranging from α = 0.86 to α = 0.95.
2. The two-item scale on provider **knowledge of inclusive communication** was designed to assess participants' perceptions of their healthcare providers' understanding of fundamental aspects of gender-affirming communication. Two specific questions were asked: (1) "How informed was the [provider type] about different gender identities?"; (2) "How informed was the [provider type] about the correct use of pronouns/name?" The internal reliability for this scale, measured across the various healthcare settings, was found to be strong, ranging from α = 0.82 to α = 0.92.
3. The single-item scale on provider **knowledge of TNB mental health** assessed participants' perceptions of their providers' awareness of mental health issues related to the (de-)transitioning process: "How informed was the [provider type] about mental health aspects related to (de-)transitioning?"
4. The two-item scale on provider **knowledge of TNB physical health** was designed to assess participants' perceptions of their healthcare providers' understanding of the physical and biological aspects of transgender and non-binary health for each healthcare setting: (1) "How informed was the [HCP] about medical gender-affirming interventions?"; (2) "How informed was the [HCP] about the biological aspects of (de-)transgender health?" The internal reliability for this scale was found to be strong, with an α value of over 0.88 across the various healthcare settings.

Variables on the Interpersonal Level

The three-item scale on **respectful communication** assesses participants' experiences with respectful language, including the correct use of names, pronouns, and inclusive terminology. Participants were asked to rate their interactions with HCP on three specific behaviors using a 5-point Likert scale, ranging from 'Never' (1) to 'Very frequently' (5): (1) "When interacting with the [HCP], how frequently did they use the correct honorifics when addressing you?"; (2) "When interacting with the [HCP], how frequently did they use the correct pronouns/name when speaking

about you?"; (3) "When interacting with the [HCP], how frequently did they use respectful and TNB-inclusive language?" The internal reliability for this three-item scale was found to be excellent, with Cronbach's ranging from 0.92 to 0.94 across the various healthcare settings.

The single-item measure on **perceived rejection** measured participants' experiences of feeling unwelcome or rejected by their HCP, on a 5-point Likert scale, ranging from 'Never' (1) to 'Very frequently' (5): "When interacting with [HCP], how frequently did you feel rejected or unwelcomed by them because of your gender identity, gender expression, or because you are intersex?"

Breaches of confidentiality is also a single item measure designed to directly assess instances of a healthcare provider sharing sensitive patient information without permission, on a 5-point Likert scale ranging from 'Never' (1) to 'Very frequently' (5): "When interacting with the HCP, how frequently did they disclose confidential information about your (de-)transition or variation in sex characteristics to third parties without your consent?"

The measure on **harm** consists of a single item designed to capture a broad range of patient safety incidents that are directly related to a person's gender identity or sex characteristics, adapted from the OECD Patient-Reported Indicator Survey[35]. Participants were asked to consider the frequency of such events in a single, overarching question: "How often do you believe you have had any such event or circumstance specifically related to your gender identity or expression or variation in sex characteristics?" The question provided examples of such events, including "not getting an appointment when needed; receiving a wrong or delayed diagnosis or treatment; or experiencing problems with communication between health care professionals." The scale was rated on a 5-point Likert scale ranging from 'Never' (1) to 'Very frequently' (5).

Variables on the Individual Level

Disclosure safety was assessed using a set of context-specific scores derived from the question: "How safe do you feel disclosing your gender in [specific healthcare setting] to [profession]?". Responses were recorded on a 5-point Likert scale ranging from 1=Very unsafe to 5=Very safe, with higher scores indicating a greater sense of safety within that specific context.

Disclosure of gender identity to **family doctor/GP** and **different social groups** was assessed with two questions: 1) "Does the family doctor or general practitioner (GP) at the clinic know your gender identity?", with a yes/no answer, and 2) "How many people in each group below currently know you are DTNBI?". The question was asked for eight social groups (e.g., immediate family, extended family, co-workers), with the following response options: 'all', 'most', 'some', 'none', 'not applicable'.

The following two individual-level scales were adapted from the GMSRM[25] to assess proximal factors related to gender identity that may impact healthcare experiences. For each of these scales, a 5-point Likert scale was used, ranging from 'Strongly disagree' (1) to 'Strongly agree' (5). For the German translation, a validated version has been used[36]. The total score for each scale was computed by summing the values of the individual items.

1. The 9-item scale for **negative expectations** assessed participants' anticipation of discrimination or poor treatment in medical settings. The adaptation involved reframing

the original items to specifically address concerns related to the documentation of gender history and/or intersex status in an EMRs (e.g., 'I am concerned that if my gender history and/or intersex status is documented in my electronic medical record, healthcare providers wouldn't accept me'). The internal reliability for this scale was also found to be strong, with a Cronbach's α of 0.88.

2. The 5-item scale for **non-disclosure behavior** assessed the extent to which individuals do not disclose their gender identity because of gender minority stressors, focusing on why people choose not to disclose (e.g., anticipated stigma, fear of rejection, concerns about confidentiality, or risk of medical or social harm). The adaptation involved reframing them to be specific to interactions and behaviors within a healthcare setting (e.g., 'Because I don't want others to know my gender history and/or that I am intersex, I don't talk about certain experiences from my past or change parts of what I will tell healthcare professionals'). The internal reliability for this scale was also found to be strong, with an alpha value of α = 0.83.

Healthcare Avoidance and Delay

Healthcare-seeking behavior was operationalized as the avoidance or delaying of needed healthcare, assessed using the question: "In the last 12 months, have you delayed or avoided seeking medical help when you needed it because you feared discrimination due to your gender identity, gender expression, or variations in sex characteristics?" Participants were asked to respond with a yes or no.

Preferences and suggestions

We asked participants about their preferences for the collection of ten sex/gender attributes (e.g., honorifics, used name, gender identity, ASAB) between these choices: 'in writing (form)', 'orally', 'in writing or orally', 'do not collect', 'I don't know') and who should have access to the information ('front desk workers', 'nurses', 'mental health professionals', 'physicians'). We asked them to rate the importance from 1 ('most important') to 7 ('least important') of seven factors that would make care more inclusive care (e.g., 'more knowledge on DNTBI-related healthcare needs', 'better addressing of their healthcare needs', improving forms), and included one free-text section on suggestions to make healthcare more inclusive.

Other measures (not presented in this report)

The instrument included another scale from the GMSRM[25] with the same Likert-type response scale: internalized transphobia (eight statements, e.g., 'I resent the variation in my sex characteristics and/or my gender identity or expression (VSCGIE)', 'My VSCGIE makes me feel like a freak)'. It also included one question on passing ("People can tell I am DTNBI even if I don't tell them", 'Always', 'most of the time', 'sometimes', 'rarely', 'never', 'prefer not to say'), the multidimensional scale of perceived social support[28], including 12 items (e.g., 'There is a special person who is around when I am in need', 'I get the emotional help and support I need from my family'), and the Brief COPE scale on coping strategies[29].

2.5 Data Analysis

Descriptive statistics were calculated to summarize the characteristics of the dataset, both for the entire population and for specific subgroups, namely gender identities. For the continuous variables, the mean *(m)* and standard deviation *(sd)* were computed to describe the central tendency and dispersion of the data. For the categorical variables, counts and percentages were calculated to show the frequency distribution within each category.

To assess the differences between gender identity subgroups, several statistical tests were employed. The exact binomial test was used to determine if the observed proportion of the binary variable differed significantly from a hypothesized population proportion *(p).* For the categorical variables, the Pearson's χ^2 test was used to determine if there were significant differences in the distribution of counts between the groups. The Cramer's V statistic was then calculated to measure the effect size of these differences. For continuous variables, one-way or two-way ANOVA were performed to test for significant differences in means across the gender identity subgroups and the healthcare contexts. When a significant difference was found, Tukey's HSD post-hoc test was applied to identify which specific groups differed from each other. ω^2 was used to quantify the effect size, providing a measure of the proportion of variance accounted for by the group differences. Effect sizes were interpreted using Cohen's rules[37].

A significance level of 0.05 was used for hypothesis tests. Computations were performed in Stata (version BE 18) and R (version 4.4.2).

2.6 Ethical Considerations

This study was conducted with careful attention to ethical guidelines to ensure the protection and privacy of all participants. An ethics clarification form was submitted to the Cantonal Ethics Committee of Vaud, which confirmed that, based on the study's design of collecting anonymous data, an authorization from ethics committee was not required. All participants provided informed consent after being presented with a detailed explanation of the project's goals. The online consent section stated that participation was voluntary and that participants could withdraw at any time without any negative consequences. To ensure confidentiality, all collected data were stored and analyzed in an anonymized and secure manner on the Unisanté server in Lausanne.

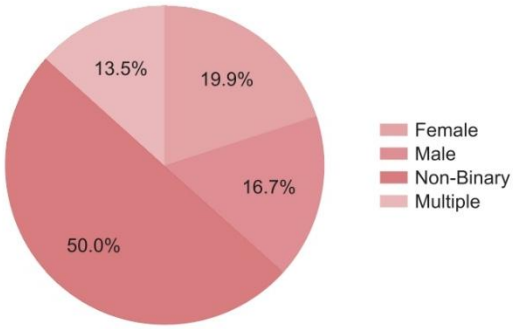
3 Results

Of the 249 individuals who met the inclusion criteria and provided their consent to participate, 156 individuals completed the survey. Figures are shown below, while tables are show in the Appendices.

3.1 Sex/Gender-Related Characteristics and Medical Transition State

Sex/gender related data and medical transition state of the participants are summarized in Table 1. Of the 156 participants, 50% identified as non-binary, 20% as female, 17% as male, and 13% selected multiple gender identities (Figure 3).

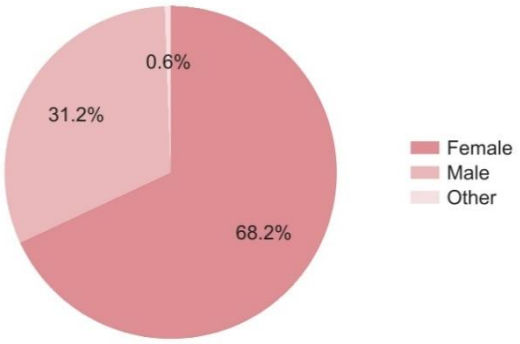
Figure 3 Distribution of Gender Identity



Distribution of participants according to their gender identities

Sixty-eight percent of the participants were assigned female at birth while 31% and less than 1% male or other, respectively (Figure 4). Significantly more of the non-binary individuals (83.3%) were assigned female at birth than male (14.1%) ($p < 0.001$).

Figure 4 Distribution of Assigned Sex At Birth



Distribution of participants according to their assigned sex at birth

Of the four participants who identified as intersex, two selected their gender identity as female and two as non-binary.

Regarding legal gender, a majority of participants (63.6%) had a female legal gender, while fewer had a male (31.8%) legal gender. A small number of individuals had a legal gender that did not align with their gender identity: five individuals with a male gender identity and seven with a female gender identity had the opposite legal gender. Among these individuals, those who had not changed their legal gender marker had a gender identity that did not match their legal gender, whereas those who had made a legal change had an identity that was consistent with it. All individuals with an "other" legal gender identified as either non-binary (71.4%) or a multiple gender identity (28.6%). Within the non-binary group, 58 individuals reported having a female legal gender, 15 with a male legal gender, and 5 with a “other” legal gender.

The respondents’ medical transition status showed distinct patterns depicted in Figure 5. A total of 22 individuals (17.2%) had no plans for medical transition, with this group consisting exclusively of those who identified as non-binary or were assigned to the multiple gender identity category. For those planning to transition, 19.4% of individuals had planned but not yet started their medical transition. The majority of this group was comprised of individuals who identified as non-binary (76.0%) or had a multiple gender identity (12.0%). The remaining participants were in various stages of transition: 40.3% of them had started but not yet completed their medical transition, and 21.7% individuals had completed it. Additionally, two individuals from the respondents had planned or completed a medical detransition. The distribution of these transition states varied significantly across the different gender identities ($p < 0.001$).

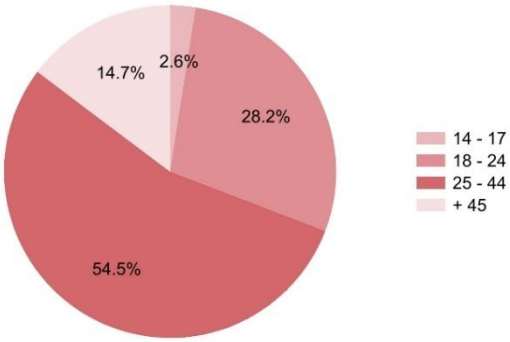
Figure 5 **Distribution by Transition Status**

Number of participants across each transition status; no plan, planned, started, finished, detransition done and detransition planed.

3.2 Socio-Demographic and Health-Related Characteristics

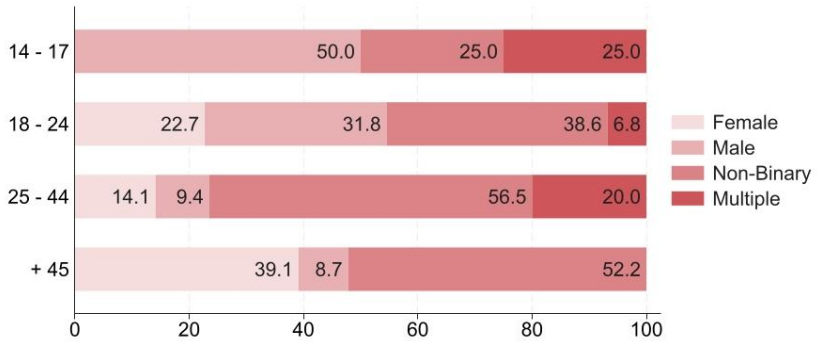
Table 2 summarize respondents' socio-demographic characteristics. The study participants were diverse in terms of age, with the majority of participants falling within the middle age categories (Figure 6). The largest group was aged 25-44 (54.5%), followed by the 18-24 age group (28.2%).

Figure 6 **Age Distribution**



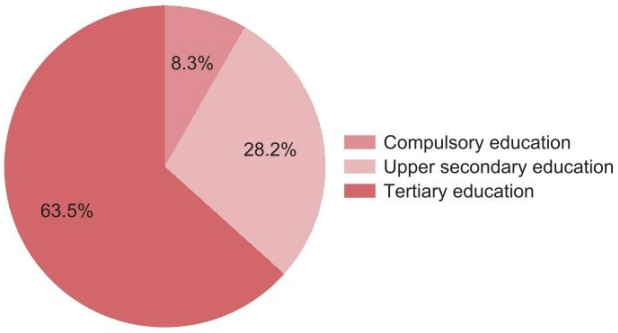
The age distributions varied significantly across the different gender identity groups (Figure 7, p = 0.002). Specifically, individuals with a male gender identity and those in the multiple gender category were relatively more represented in the younger age categories, while those with a female gender identity were more prevalent in the older age categories. Non-binary individuals dominated in the middle age categories.

Figure 7 Distribution of Gender Identity Across Age Groups



Most respondents had a tertiary level of education (63.5%), followed by upper secondary (28.2%) and compulsory education (8.3%) (Figure 8). There were no significant differences in education levels across gender identities (p = 0.175).

Figure 8 Highest Level of Education Distribution



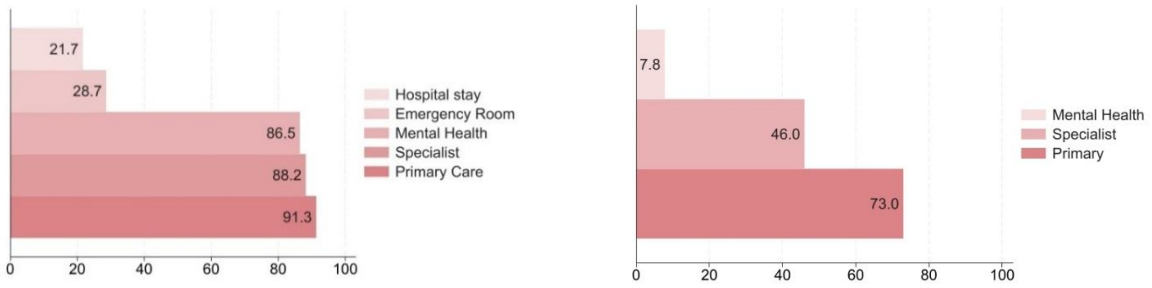
About a quarter of respondents (23.7%) reported experiencing financial strain and there were no significant differences in the distribution of financial strain across the gender identities (p = 0.095).

The majority of responses indicated generally positive health perceptions: 40% of the individuals reported having good health status, followed by 30% for fair health, and 17% for very good health. There was a statistically significant relationship between subjective health status and gender identity (p = 0.02), with moderate strength (Cramer's V = 0.23). An examination of the contingency table showed a trend where female individuals tended to report a better subjective health status, while non-binary individuals tended to report a poorer one. Detail numbers are provided in Table 2.

3.3 Healthcare Use and Avoidance/Delay

Data on the healthcare use of study participants over the last 12 months were collected (Figure 9, and Table 3). The most frequently used services were primary care (91.3%), specialized care (88.2%), and mental health services (86.5%), in contrast to emergency department visits (28.7%) and hospital stays (21.7%). These rates are substantially higher than those reported for the general Swiss norm population (73.0% for primary care and 46% for specialized care) [38]. The disparity is particularly stark in mental health usage, where the cohort's rate of 86.5% is much higher than the 7.8% reported for the general Swiss population. No significant differences were found in healthcare use across the different gender identities.

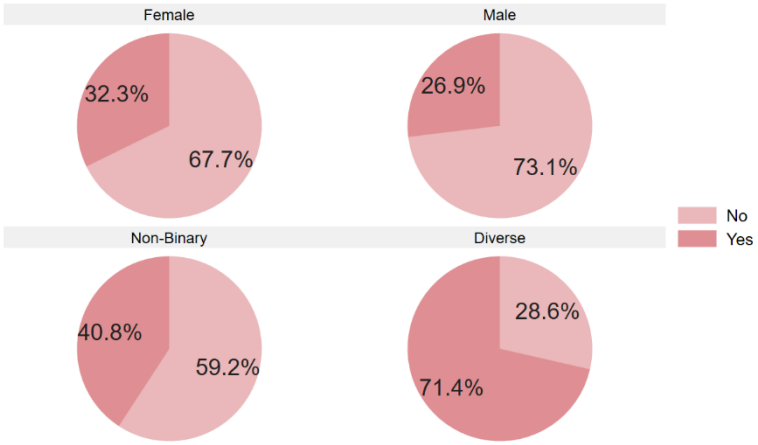
Figure 9 **Distribution of Healthcare Use for TNB Individuals and Swiss Population**



Percentage of healthcare use for each sector, respectively for TNB individuals (left) and the general Swiss population (right).

A total of 63 individuals (40.9%) reported having delayed or avoided healthcare at least once in the past 12 months due to fear of being disrespected or mistreated because of their gender identity (Table 4). Significant differences were observed across gender identities (p = 0.013) with a higher proportion of individuals in the multiple gender identity group (71.4%) and non-binary people (40.8%) who delayed or avoided care (Figure 10). This was in contrast to individuals with a female gender identity (32.3%) and a male gender identity (26.9%).

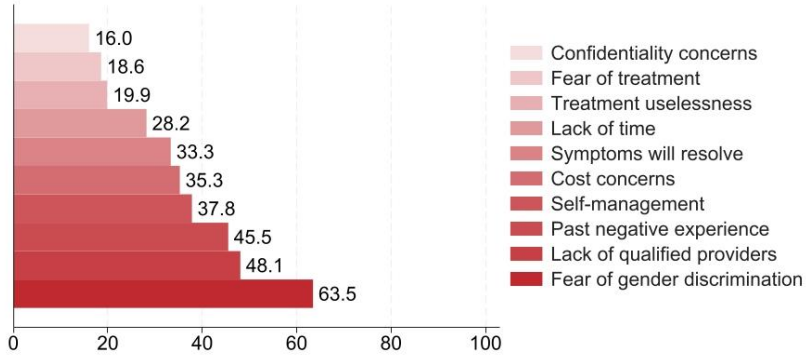
Figure 10 Healthcare Avoidance in the Last 12 Months by Gender Identity



Percentage of participants within each gender identity who reported avoiding healthcare in the past 12 months.

Among the participants, three primary reasons were reported for avoiding healthcare for health problems (Figure 11): (a) fear of experiencing gender-related discrimination (63.5), (b) lack of access to qualified healthcare professionals (48.1%), and a negative health service experience in the past (45.5%). There was a statistically significant difference only across gender identities for past negative experience (p = 0.011). Specifically, this reason was cited by 54.4% of individuals identifying as non-binary and 66.7% of those with multiple gender identity. In contrast, this reason was mentioned by a smaller percentage of individuals identifying with a binary gender identity.

Figure 11 Reasons for Healthcare Avoidance



Reasons for healthcare avoidance and their prevalence rate across participants.

3.4 Experiences at the Structural level

3.4.1 Sex/Gender Accuracy, Form Inclusivity and Ease of Change

Participants reported that honorifics, names, pronouns, and gender identity were used with varying degrees of accuracy in e-mail correspondence and forms across different healthcare settings (Table 5). The overall mean accuracy score was *m* = 3.76 (*sd* = 1.32) on a scale from 1 to 5, indicating that this information was occasionally to frequently used correctly.

The effect of gender identity **on sex/gender accuracy** was examined. A statistically significant difference in accuracy was observed across gender identities (ω^2 = 0.21 with 95%-CI = [0.15; 1.00]). Findings reveal that individuals with binary gender identities experienced the highest level of accuracy, corresponding to frequently to very frequently correct usage, in contrast to non-binary individuals who reported correct usage only seldom to occasionally. The factor of healthcare context also showed a statistically significant main effect on accuracy ($p < 0.05$, ω^2 = 0.15). Sex/gender accuracy was rated lowest – as seldom to occasionally correct – in administrative and general contexts, including emergency departments (2.79), non-gender clinics (2.88), and insurance providers (*m* = 2.97). Conversely, the highest accuracy, corresponding to frequently to very frequently correct usage, was reported in specialized mental health settings: psychiatrists (*m* = 4.15), gender clinics (*m* = 4.13), and particularly psychologists (*m* = 4.63).

The variable **form inclusivity** capturing participants' ratings of the inclusivity of questions and answer options on forms showed that the forms were generally designed to be seldom to occasionally inclusive (overall *m* = 2.72, *sd* = 1.34). There was a statistically significant main effect for gender identity in inclusivity rating (ω^2 = 0.24, 95%-CI = [0.18; 1.00]). Individuals with binary gender identities reported forms were occasionally to frequently inclusive, while non-binary and multiple gender identity groups reported forms were never to seldom inclusive. A statistically significant main effect for healthcare context was also observed ($p < 0.05$, ω^2 = 0.162 and 95%-CI = [0.10; 1.00]). The highest ratings, indicating occasionally to frequently inclusive forms, were given to psychologists (*m* = 3.46), gender clinics (*m* = 3.40), and psychiatrists (*m* = 3.44). Conversely, the lowest ratings, indicating never to seldom inclusive forms, were given to insurance providers (*m*=2.00), non-gender clinics (*m*=1.82), and emergency departments (*m*=1.77).

The final variable assessed was participants' ratings of **ease of change of attributes** (e.g., changing name, legal gender, pronouns, or gender identity). Overall experience was rated as 3.21 (*sd* = 1.42), suggesting the process was generally perceived as slightly above the threshold for difficult to change. Finally, there were statistically significant main effects for both gender identity and healthcare context on ease of change. The effect of gender identity was highly significant (ω^2 = 0.34, 95%-CI = [0.26;1.00]). Binary individuals reported the most positive experiences, while non-binary individuals reported a significantly worse experience perceiving the process as very difficult to difficult. The main effect of healthcare context was also statistically significant (ω^2 = 0.04, 95%-CI = [0.00;1.00]). Ratings ranged from the lowest scores at non-gender clinics (*m* = 2.63) to the highest at gender clinics (*m* = 3.74).

3.4.2 Perceived Providers' Knowledge

The results of the participants' ratings of their healthcare providers' knowledge are presented in Table 6).

Knowledge of inclusive communication was on average between "somewhat informed" and "well informed" (m = 3.83, sd = 1.00). The analysis revealed a statistically significant main effect of participants' gender identity ($p < 0.001$), explaining a moderate proportion of the variance (ω^2 = 0.21). Male and female participants perceived their providers as "well informed" to "very well informed", in contrast to non-binary individuals (m = 3.48, sd = 1.06) and those in the multiple gender category who rated their providers' knowledge significantly lower, between "somewhat informed" and "well informed." Regarding the healthcare setting, participants rated providers in gender clinics (m = 4.31, sd = 0.86) and psychologists in mental health contexts (m = 4.28, sd = 0.83) highest, perceiving them as "well informed" to "very well informed" Conversely, providers in emergency departments received the lowest rating overall (m = 2.50, sd = 1.47), suggesting they were perceived as "not very informed" to "somewhat informed." Pronounced differences were observed when analyzing non-binary individuals' ratings across contexts. While non-binary individuals' overall ratings were low, they rated psychologists positively (m = 4.18, sd = 0.80). However, they gave the lowest ratings, falling between "not at all informed" and "somewhat informed," for specialized physicians in non-gender clinics (m = 2.93, sd = 1.32), physicians in hospitals (m = 2.86, sd = 1.38), psychiatrists in mental health contexts (m = 2.86, sd = 1.38), and especially low ratings for physicians in emergency departments (m = 1.60, sd = 0.81).

Providers' **knowledge of TNB mental health** was assessed and rated overall as falling between "somewhat informed" and "well informed" (m = 3.61, sd = 1.13), with a statistically significant main effect for gender identity ($p < 0.001$), which was linked to a moderate effect size (ω^2 = 0.08). Participants identifying with a binary gender consistently awarded higher ratings for providers' mental health knowledge (female: m = 3.84, sd = 1.02; male: m = 4.19, sd = 0.91) compared to non-binary individuals (m = 3.41, sd = 1.21) and those in the multiple group (m = 3.18, sd = 0.99). Furthermore, a highly significant main effect was identified for healthcare context ($p < 0.001$), demonstrating a larger effect size (ω^2 = 0.158). Psychologists were rated significantly above all other provider categories. This context was the sole setting to be perceived as "well informed" to "very well informed" overall (m = 4.32, sd = 0.98). All other contexts received average ratings spanning between "not well informed" and "well informed". A closer examination of non-binary individuals' ratings across settings highlighted sharp contrasts. While non-binary participants generally provided low overall scores, they rated psychologists positively (m = 4.18, sd = 0.80). However, non-binary individuals reported the most critical scores, falling between "not at all informed" and "somewhat informed", for psychiatrists (m = 2.93, sd = 1.44), physicians in hospitals (m = 2.60, sd = 1.14), specialist physicians in non-gender clinics (m = 2.44, sd = 1.26), and dramatically low for physicians in emergency departments (m = 2.00, sd = 0.82).

Participants evaluated providers' **knowledge of TNB physical health** with a mean score of m = 3.63 (sd = 1.10), which falls slightly above the scale point representing "somewhat informed". There was a statistically significant main effect for gender identity ($p < 0.001$), associated with a moderate effect size (ω^2 = 0.11). Participants identifying with a binary gender reported significantly higher scores (m = 3.94, sd = 1.03 for female; m=4.16, sd = 1.01 for male) compared to both non-binary (m

= 3.40, *sd* = 1.30) and multiple gender groups (*m* = 2.95, *sd* = 1.28). A second significant main effect was found for healthcare context ($p < 0.001$), also showing a moderate effect size ($\omega^2 = 0.11$). Physicians from gender clinics (*m* = 4.36, *sd* = 0.80), physicians in hospitals (*m* = 3.98, *sd* = 1.19), and psychologists (*m* = 3.72, *sd* = 1.21) were rated as significantly better informed than were physicians working in emergency departments (*m*=2.65, *sd*=1.35). Furthermore, a specific examination of the multiple gender group highlights several concerningly low ratings. Individuals in this group reported particularly low scores across multiple settings: psychiatrists (*m*=2.83, *sd*=1.63), physicians working in hospitals (*m* = 2.75, *sd* = 1.06), specialized physicians in non-gender clinics (*m* = 2.33, *sd* = 0.58), and general practitioners/family doctors (*m* = 2.25, *sd* = 0.89). The lowest rating observed was for physicians in emergency departments (*m* = 1.50), though the standard deviation was not available for this data point.

The final variable concerning provider competence, **knowledge about the social aspects of trans lives,** received the lowest overall rating compared to the other knowledge variables, with a mean score of *m* = 3.31 (*sd* = 1.08). This mean is situated near the scale point representing "somewhat informed". There was a highly significant main effect for gender identity, ($p < 0.001$), which was associated with a large effect size ($\omega^2 = 0.15$). Participants with binary gender identities reported higher mean ratings (*m* = 3.77, sd = 1.04 for female; *m* = 3.89, *sd* = 1.05 for male) compared to both non-binary individuals (*m* = 2.87, *sd* = 1.31) and those in the multiple gender category (m = 2.85, *sd* = 1.32). A second statistically significant main effect was found for healthcare context ($p < 0.001$), demonstrating the largest effect size of all variables in this section ($\omega^2 = 0.20$). Psychologists were the only providers rated as "well informed" overall (*m* = 4.05, *sd* = 0.97). Physicians in all other groups received significantly lower ratings, with the exception of physicians in gender clinics (*m* = 3.68, *sd* = 1.07), whose score was closer to the overall mean. Low mean scores were specifically observed for physicians in hospitals (*m* = 2.98, *sd* = 1.28), in primary care (*m* = 2.93, *sd* = 1.27), in non-gender clinics (*m* = 2.50, *sd* = 1.13), and in emergency departments (*m* = 2.09, *sd* = 1.13). This lack of social knowledge was particularly acute when examining ratings by non-binary individuals and those of the multiple gender group. For physicians in emergency departments, both groups reported exceptionally low mean values (*m* = 1.62, *sd* = 0.74 for non-binary; *m* = 1.50, *sd* = 0.71 for multiple group). Given that 1 = Not at all informed and 2 = Not very well informed, these scores indicate participants in these groups perceived providers in emergency settings as having virtually no sociological knowledge related to trans lives.

3.5 Experiences at the Interpersonal level

3.5.1 Respectful Communication

The results of participants' ratings of their healthcare providers' communication skills are presented in Table 7. Participants' overall rating of providers' respectful communication was *m* = 3.79 (*sd* = 1.17), which is positioned between the scale points representing "occasionally" (3) and "frequent" (4). The test revealed a highly significant main effect for gender identity ($p < 0.001$), associated with a large effect size ($\omega^2 = 0.20$). A clear distinction was found between binary and non-binary groups: female (*m* = 4.46, *sd* = 0.66) and male (*m* = 4.65, *sd* = 0.58) participants reported the highest

frequencies of respectful communication, perceiving it significantly more often than the non-binary (m = 3.26, sd = 1.20) and the multiple gender group (m = 3.62, sd = 1.10).

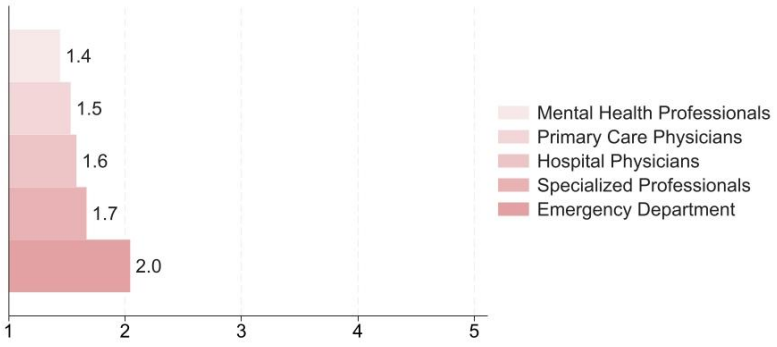
A highly significant main effect was also found for healthcare context ($p < 0.001$), which was linked to a large effect size ($\omega^2 = 0.20$). Psychologists (m = 4.66, sd = 0.60) and physicians in gender clinics (m = 4.52, sd = 0.76) communicated respectfully with similar, significantly high frequency compared to other healthcare contexts. Conversely, physicians in the emergency department (m = 2.51, sd = 1.61) communicated respectfully significantly less often than most other contexts, with the exception of specialized physicians in non-gender clinics (m = 3.08, sd = 1.41), whose communication was rated similarly low.

Non-binary individuals consistently reported exceptionally low frequencies of respectful communication. While psychiatrists (m = 2.97, sd = 1.33), physicians in hospitals (m = 2.98, sd = 1.54), and specialized physicians in non-gender clinics (m = 2.95, sd = 1.43) communicated respectfully only around "occasionally" to this group, physicians in emergency departments received scores (m = 3.67, sd = 1.60), indicating communication was perceived as between "never" (1) and "seldom" (2).

3.5.2 Perceived Rejection

Overall, TNB individuals reported feeling rejected by healthcare professionals infrequently, with a mean rating of m=1.64 (sd = 0.85), which is situated between the scale points of "never" (1) and "seldom" (2) (Table 7). A statistically significant main effect for gender identity ($p < 0.001$), although the effect size was small to moderate ($\omega^2 = 0.056$). Male participants (m = 1.16, sd = 0.30) felt significantly less frequently rejected compared to non-binary individuals (m = 1.77, sd = 0.85) and those in the multiple gender category (m = 2.02, sd = 1.06). Female participants reported similar values (m = 1.46, sd = 0.82), which were significantly lower than the multiple group but did not statistically differ from the male or non-binary groups, thus failing to support the prediction across all groups. A second statistically significant main effect was observed for healthcare context (Figure 12, p = 0.006) with a small effect size ($\omega^2 = 0.04$). A significantly lower frequency of perceived rejection from psychologists (m = 1.27, sd = 0.74) compared to physicians in non-gender clinics (m = 1.95, sd = 1.16) and in emergency departments (m = 2.05, sd = 1.21). For the remaining healthcare contexts (including gender clinics, hospitals, psychiatrists, and primary care), no statistically significant differences in perceived rejection were established between them or with the contexts listed above.

Figure 12 Perceived Rejection by Healthcare Setting



Perceived rejection by health settings, measured on a scale from 1 (never) to 5 (very frequently).

3.5.3 Breach of Confidentiality and Harm

Overall, participants reported that confidentiality was very rarely breached (*m* = 1.22, *sd* = 0.64), falling between the scale points of "never" (1) and "seldom" (2) (Table 7). The analysis revealed no statistically significant effect for gender identity (p = 0.87). This finding suggests that all gender identity groups experienced similarly low frequencies of confidentiality breaches. Similarly, the main effect for healthcare context was also non-significant (p = 0.969).

Participants reported on their experiences with harmful events in healthcare, encompassing events like being refused an appointment or receiving harmful treatment due to their gender identity, presented in Table 8. The most common response indicated that this occurred only occasionally (34.8%). Breaking down the responses, 21.3% of participants stated they never experienced harm, 22.6% reported it seldom occurred, 9.0% reported it frequently, and 2.6% reported it very frequently. No evidence of a relationship between gender identity and the frequency of harm was found (p = 0.963).

3.6 Experiences on the Individual level

3.6.1 Disclosure Safety

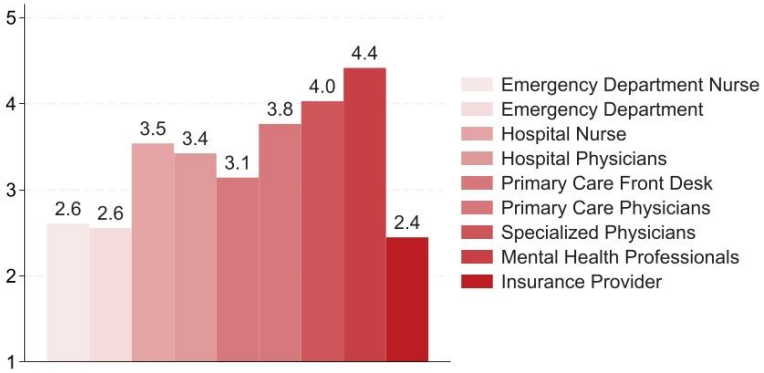
Participants' overall perception of the safety of disclosing their gender identity received a mean rating of *m* = 3.76 (*sd* = 1.06), indicating a score between "neutral" (3) and "moderate safe" (4) on the 5-point scale (see Table 9).

A substantial and highly significant difference based on gender identity ($p < 0.001$), associated with a large effect (ω^2 = 0.18). An examination of the means showed that binary participants reported consistently higher safety levels, with female participants scoring *m* = 4.42 (*sd* = 0.66) and male participants scoring *m* = 4.30 (*sd* = 0.87). This stood in sharp contrast to non-binary individuals (*m* = 3.40, *sd* = 1.07) and those in the multiple gender category (*m* = 3.38, *sd* = 0.98), whose scores were significantly lower and hovered near the "neutral" midpoint.

The analysis also demonstrated a highly potent main effect attributable to the healthcare context (Figure 13, $p < 0.001$), representing a very large proportion of the variance ($\omega^2 = 0.36$). Psychologists were perceived as the safest context for disclosure (m = 4.67, sd = 0.65), with safety ratings significantly exceeding those for all other healthcare settings and entities, including insurance providers. Participants also felt high levels of safety with specialized physicians in gender clinics (m = 4.33, sd = 1.12). Perceived safety diminished across other settings, falling to moderate levels for psychiatrists (m = 3.93, sd = 1.37) and physicians in primary care (m = 3.76, sd = 1.29), non-gender clinics (m = 3.68, sd = 1.30), and hospitals (m = 3.54, sd = 1.48). The lowest overall scores were assigned to physicians in emergency departments (m = 2.56, sd = 1.28) and disclosure towards insurance providers (m = 2.45, sd = 1.23).

A breakdown by specific groups reveals the lowest safety scores were concentrated among non-binary and multiple-gender participants in particular contexts. Non-binary individuals reported safety levels approaching "moderately unsafe" for physicians in emergency departments (m = 1.94, sd = 0.99) and when dealing with insurance providers (m = 1.97, sd = 1.00). Likewise, the multiple gender group expressed the lowest safety perceptions towards insurance providers (m = 1.90, sd = 0.77).

Figure 13 Safety to Disclose Gender Identity



Mean safety to disclose gender identity in different health settings, measured on a scale from 1 (very unsafe) to 5 (very safe).

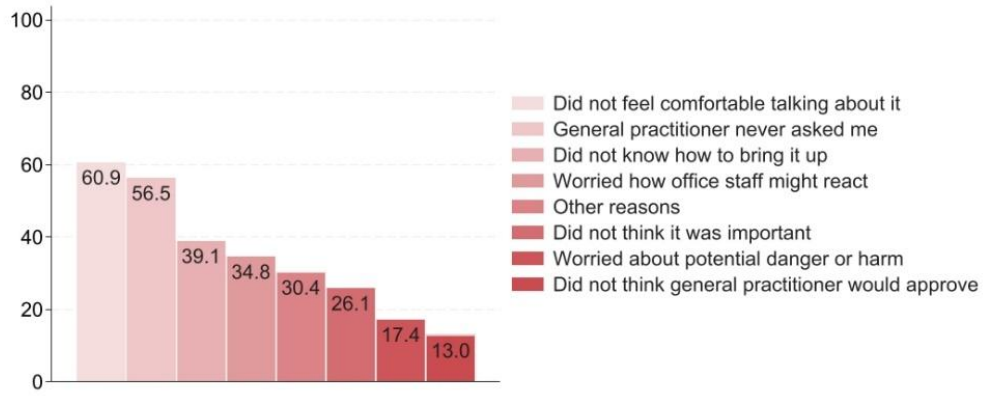
3.6.2 Disclosure of Gender Identity

Disclosure of Gender Identity to Primary Care Provider

Out of the 156 participants, 104 provided information regarding the disclosure of gender identity to their primary care provider. While 82% think it's (very) important for the primary care provider to know their gender identity, about three quarters (77%) indicated having shared this information and. The following figure (Figure 14) focuses on the remaining quarter, who have not disclosed their gender identity to their primary care provider, exploring the reasons underlying this decision. The main reason is not feeling comfortable talking about it, closely followed by the physicians never asking them about it, and in third and fourth place, participants did not know how to bring it up

and were worried about the office staff's reaction to this information. These responses illustrate how communication barriers influence disclosure.

Figure 14 Non-Disclosure of Gender Identity to Primary Care Provider

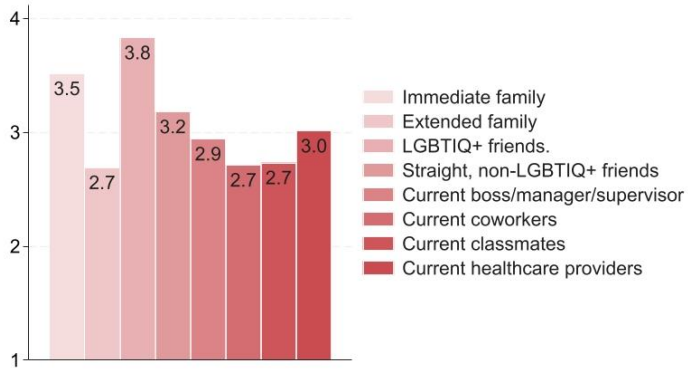


Reasons for not disclosing gender identity to primary care provider

Disclosure of Gender Identity to Different Social Groups

Besides healthcare providers, DTNBI individuals disclose personal information on their gender identity differently across the many multiple groups that shape their daily lives. With a score ranging from 1 (none) to 4 (all of them), there is a major difference between categories, even ones that may seem similar (Figure 15). Family members were divided into two distinct groups: immediate and extended family, both reflecting distinct results. Disclosure to extended family showed a low score of $m = 2.7$ ($sd = 1.19$), between "some" and "most" extended family members knowing about gender identity. This level of disclosure is in line with the results for disclosure among classmates ($m = 2.73$, $sd = 1.09$), coworkers ($m = 2.71$, $sd = 1.12$), and supervisors ($m = 2.94$, $sd = 1.29$). In contrast, disclosure to immediate family was higher with a score of $m = 3.5$ ($sd = 0.94$). This is higher than disclosure to straight/non-LGBTQ+ friends ($m = 3.18$, $sd = 0.89$) and slightly lower than disclosure to LGBTQ+ friends ($m = 3.83$, $sd = 0.48$).

Figure 15 Disclosure of Gender Identity per Social Group

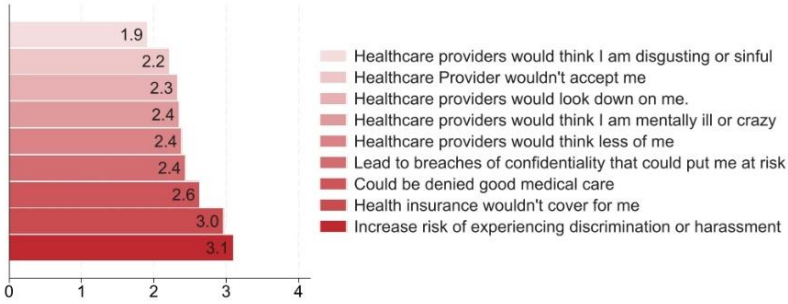


Disclosure of Gender Identity or Variation in Sex Characteristics per Social Group, measured on a scale from 1 (none) to 4 (all).

3.6.3 Negative Expectations

Regarding negative expectations regarding healthcare experiences (Table 10), participants reported an overall mean value of *m* = 22.42 (*sd* = 7.33). Given the scale's range (0-36), this mean suggests that, on average, participants report a moderate to high level of negative expectations concerning their interactions with healthcare providers. The strongest concerns reported were fear of discrimination or harassment within the healthcare setting (*m* = 3.12, *sd* = 1.06) and fear of limitations in health insurance coverage (*m* = 2.99, *sd* = 1.11) (Figure 16). Statistical analysis revealed no statistically significant differences between the groups (*p* = 0.121).

Figure 16 Individual Score of Each Negative Expectation in Healthcare



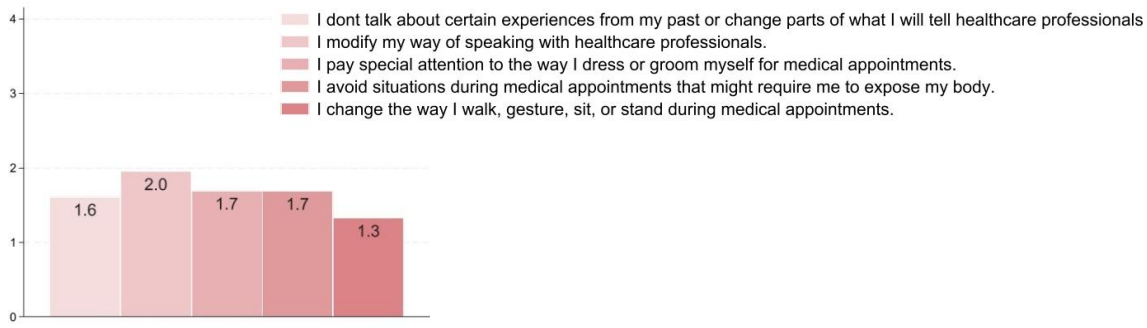
Individual score of each negative expectation, measured on a scale from 0 (strongly disagree) to 4 (strongly agree).

3.6.4 Non-Disclosure Behavior

Non-disclosure of gender identity in the healthcare context is shown in Figure 17 and Table 10. Participants reported an overall mean value of *m* = 8.24 (*sd* = 5.33). This mean value suggests that, on average, participants report a low to moderate extent of engaging in non-disclosure behaviors within healthcare settings. Highest-rated non-disclosure behavior was the modification of one's

way of speaking with healthcare professionals (*m* = 2.0, *sd* = 1.40). No statistically significant differences across gender identities were found (*p* = 0.799).

Figure 17 Non-Disclosure of Gender Identity in Healthcare, by Behavior



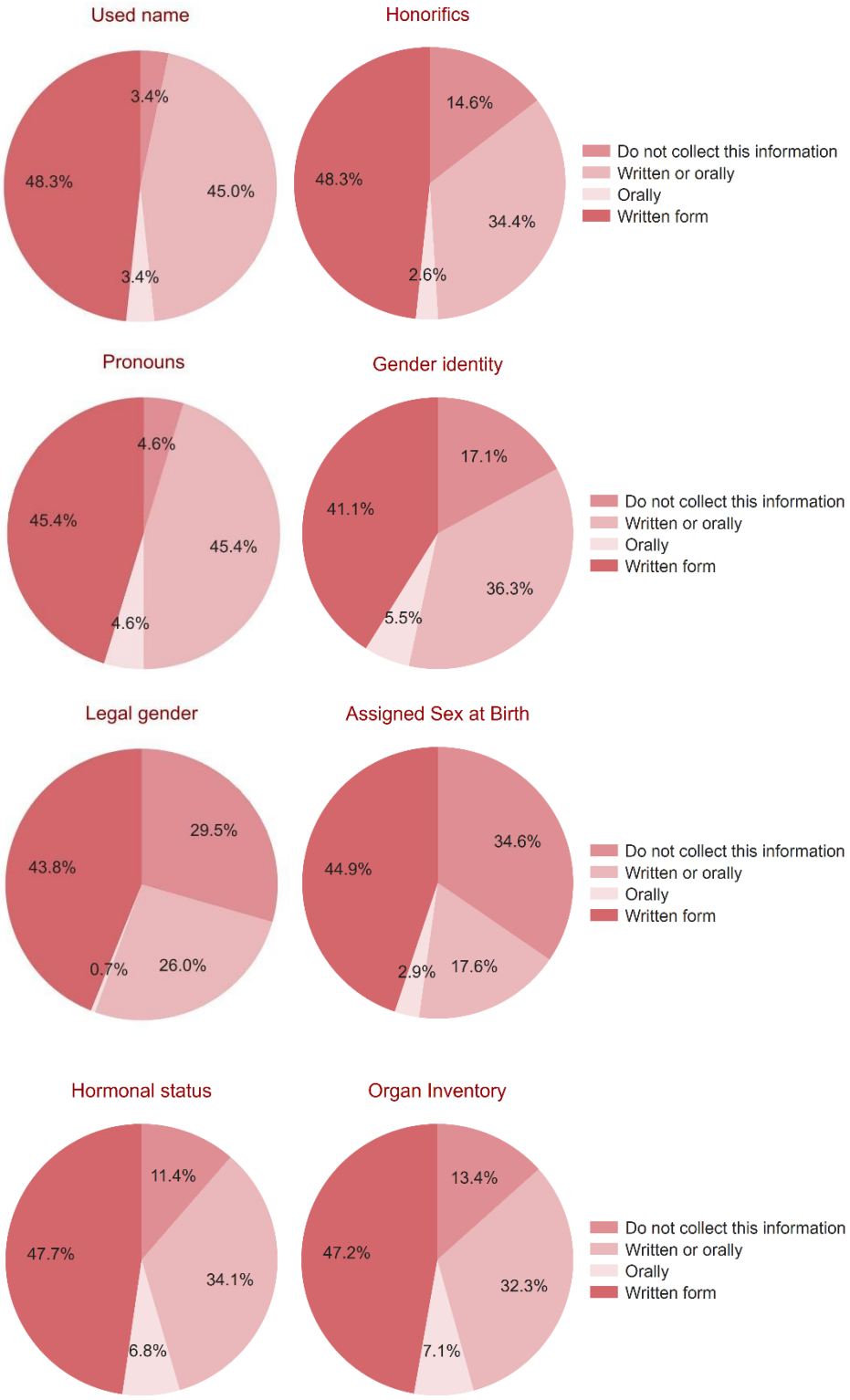
Score of each non-disclosure behavior, measured on a scale from 0 (strongly disagree) to 4 (strongly agree).

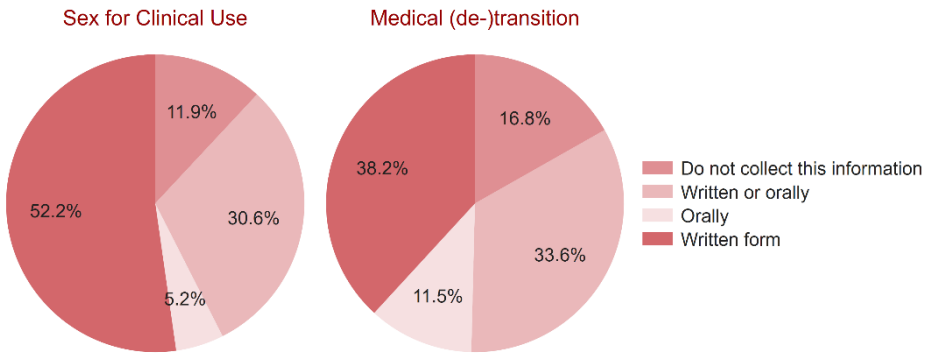
3.7 Preferences and Suggestions for More Inclusive Healthcare Services

3.7.1 Preferred Modes of Collection for Sex- and Gender- Related Information

Figure 18 provided a visualization of the distribution of the preferred mode of collection for sex/gender information and attributes. Overall, the majority consistently preferred the written form over oral form. ASAB and legal gender are the two attributes with the highest percentage of no collection (35% and 30%, respectively). When it comes to more medical aspects, such as organ inventory, hormonal status or medical (de-)transition, there is some pushback with 11% to 17% not wanting this information to be collected.

Figure 18 Preferred Form of Collection of Sex-/Gender- Related Information



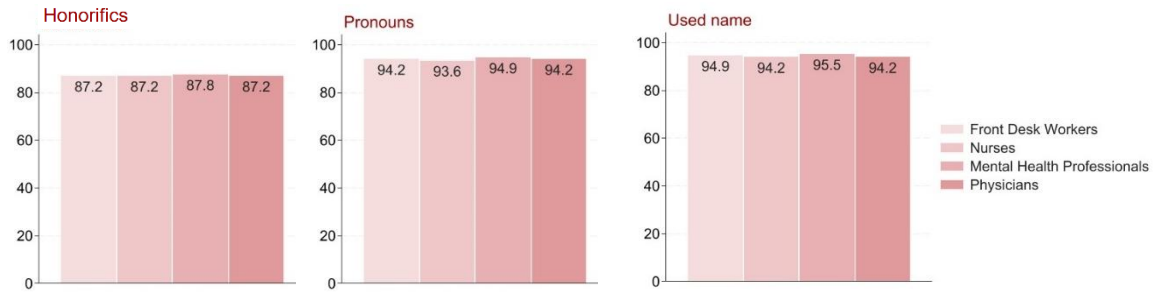


3.7.2 Preferences regarding Access to Sex/Gender Information

Participants were asked which medical personnel should have access their sex and gender-related information, classified as communication-related information (honorifics, pronouns, used name), identity- and administrative-related information (gender identity, legal gender, ASAB), and medical-related information (hormonal status, organ inventory, medical (de-)transition, sex for clinical use). Healthcare workers were divided into four groups: front desk workers, nurses, mental health professionals, and physicians. Preferences in accessibility varied depending on the sensitivity and the relevance of the information.

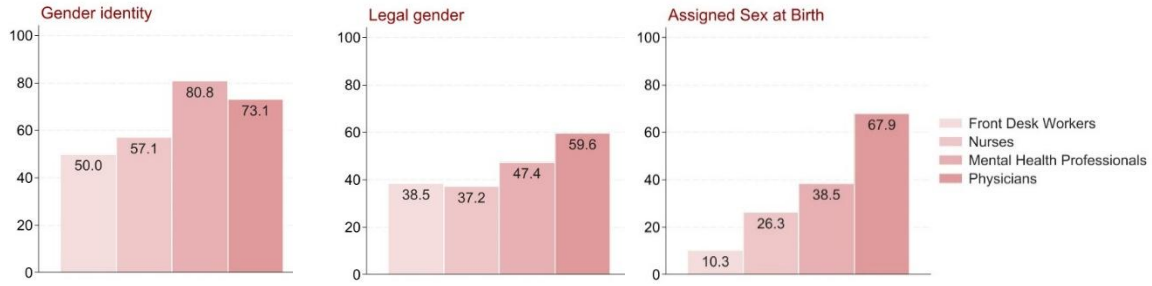
Regarding communication-related information (Figure 19), participants did not indicate specific preferences or restrictions regarding its access, which was consistently rated high, ranging from 87.2% to 95.5%, across the different categories and for all healthcare professionals.

Figure 19 Communication-Related Information



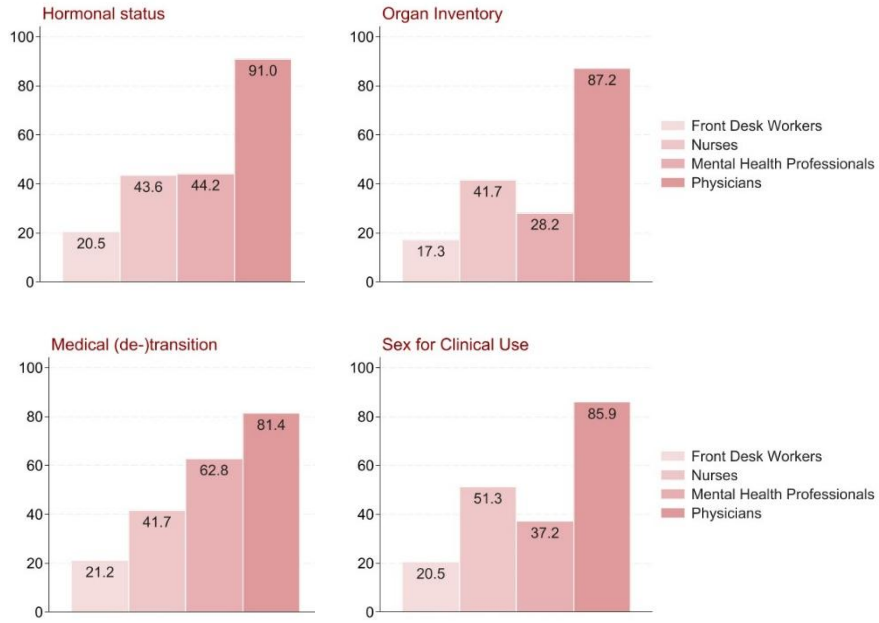
Preferences became more pronounced for identity- and administrative-related information (Figure 20), where differences between professionals emerged. Gender identity was frequently deemed as appropriate to share with several actors within the healthcare setting, whereas ASAB was considered more sensitive and subject to more control, with only 10% of participants willing to share this information with front desk workers.

Figure 20 Identity- and Administrative-Related Information



The greatest disparity was observed in access to medical-related information (Figure 21). Participants categorized hormonal status and organ inventory as sensitive medical information that should be controlled, with limited access primarily granted to physicians. Front desk workers consistently ranked the lowest in terms of access. Overall, a preference for a more controlled dissemination of medical information was found, leaving primary access to physicians.

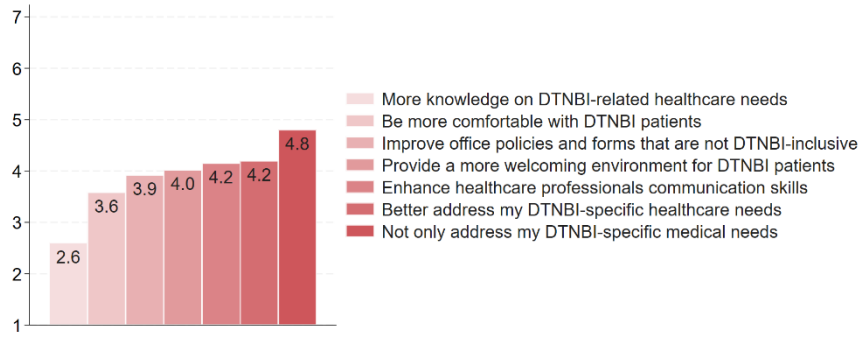
Figure 21 Medical-Related Information



3.7.3 Priorities for Service Improvement

Participants were asked to rank seven options that could improve healthcare experiences for DTNBI patients, with 1 indicating the most important one and 7 the least. The ranking indicated that increasing provider's knowledge on DTNBI-related needs is, by far, the highest on the priority list (m = 2.6, sd = 1.78) (Figure 22), highlighting a gap in providers' expertise and hindering the healthcare experience for DTNBI individuals. This aspect was also reflected in the open-ended comments provided by participants (Table 13).

Figure 22 Proposed Improvements for More Inclusive Healthcare Services



Proposed improvements, measured on a scale from 1 (most important) to 7 (least important).

In second place, participants pointed out that providers should be more comfortable with DTNBI patients (*m* = 3.59, *sd* = 1.77). This indicates that, beyond a lack of knowledge, participants perceived discomfort from their providers. The third priority is the need to change office policies and forms that are not DTNBIs inclusive (*m* = 3.92, *sd* = 1.83). Fourth is the need to provide a more welcoming environment for DTNBI patients (*m* = 4.02, *sd* = 1.95), highlighting a lack of accessibility and inclusivity of healthcare. The fifth and sixth priorities are enhancing providers' communication skills (*m* = 4.15, *sd* = 2.04) and better addressing DTNBI-specific healthcare needs (*m* = 4.2, *sd* = 1.83), respectively. While lower in ranking, these dimensions remain important, as shown by their relatively close mean values. Lastly, the lowest priority was not addressing DTNBI-specific medical needs alone (*m* = 4.80, *sd* = 2.06), indicating that participants prioritize foundational improvements in knowledge and inclusivity before the expansion of services.

3.7.4 Free-text comments on positive and negative experiences and suggestions for improvement

We asked participants to share positive and negative experiences related to their sex/gender identity or expression, summarized in Table 11 (comments from 107 respondents) and Table 12 (comments from 110 respondents), as well as suggestions to make healthcare services more DNTBI-inclusive, summarized in Table 13 (comments from 34 participants).

A key theme of positive healthcare experiences was the respectful use of chosen names, pronouns, and forms of address, with healthcare professionals actively asking for this information, documenting it, and taking steps to avoid misgendering. Even when professionals lacked formal training on trans health, many participants valued empathetic, human-centered care, characterized by openness, active listening, humility, and a willingness to learn. Specialized and gender-affirming services were consistently described as safer and more trustworthy, often providing higher-quality and more informed care. Participants also highlighted administrative flexibility, such as inclusive forms, neutral correspondence, and adapted insurance or billing practices, which conveyed recognition and relief. Finally, smooth access to transition-related care without gatekeeping (e.g., hormones, surgery, referrals) was experienced as validating and effective, contributing to reduced dysphoria and greater wellbeing.

Regarding negative experiences, participants described wide-ranging ones that generated distress, exhaustion, and loss of trust. Recurrent misgendering, deadnaming, and disrespectful forms of address, often persisting despite correction or legal changes, were common and contributed to feelings of invisibility and unsafety. Many reported intrusive, inappropriate, or dysphoria-inducing questions unrelated to care, experienced as humiliating and invasive. A lack of provider knowledge and clinical competence regarding trans health led to frustration, dismissal of symptoms, and sometimes unsafe or inadequate treatment. Participants also faced gatekeeping and pathologization, including excessive psychiatric requirements and delegitimization of their identities, which produced feelings of powerlessness and anger. Structural problems such as binary administrative systems, outdated IT records, and insurance barriers resulted in exclusion, delays, financial stress, and denied care. Additional harms included breaches of confidentiality, experiences of explicit discrimination and transphobia by professionals, and long waiting times for treatments. Collectively, these experiences created a substantial emotional burden, leading many participants to conceal their identity, avoid care, or self-censor to protect themselves from further harm.

Participants offered recommendations to improve healthcare experiences for trans, non-binary, and intersex people. Central among these was the need for better initial and ongoing training of healthcare professionals to ensure clinical competence, awareness of DTNBI realities, and understanding of dysphoria and transition-related care. Participants emphasized respectful, patient-centered communication, including active listening, validation of lived experiences, and avoidance of unnecessary or intrusive questions. Many called for more inclusive and de-gendered medical language, favoring anatomically precise terminology over gendered assumptions. Suggestions also focused on inclusive infrastructure and hospital practices, such as gender-neutral toilets and respectful room assignment during hospitalization, to ensure safety and dignity. Participants highlighted the importance of administrative and IT systems that reflect gender diversity, allowing non-binary options, easy updates to names and salutations, and differentiated data use. Strong demands were expressed for data protection, transparency, and control over personal information to prevent unwanted disclosure. Visible signals of inclusion (e.g. inclusive forms, pronoun sharing, symbols) were viewed as essential to reduce fear and uncertainty. Finally, participants called for easier, non-pathologizing access to transition-related care, reduced gatekeeping and insurance barriers, and better coordination and shared responsibility among providers to ensure continuity and reliability of care.

4 Discussion

The study showed significant heterogeneity in experiences based on both participants' gender identity and healthcare setting. Specifically, non-binary and multiple gender individuals reported experiencing significantly more adverse events, including misgendering, the use of incorrect sex/gender attributes, and encountering non-inclusive data collection processes. Furthermore, differences were observed across settings and professional roles: adverse experiences were reported less frequently in gender clinics and mental health settings compared to non-gender clinics and emergency departments. Conversely, experiences with psychological psychotherapists were significantly more often positively perceived than those with psychiatrists or physicians. Similarly, provider knowledge related to TNB health are rated higher for psychologist than for psychiatrists and physicians except for physicians working in gender clinics for knowledge of TNB physical health.

4.1 Healthcare Use and Avoidance/Delay

Participants reported very high **healthcare use** over the past 12 months, particularly for primary care (91%), specialized care (88%), and mental health services (86%). These rates were substantially higher than those of the general Swiss population[38, 39], especially for mental health care. In addition, the population data used for comparison[39] includes older individuals (50−65 as well as 65+), who are demographic groups with documented higher healthcare utilization. Since the study's younger age would normally be expected to show lower utilization, this contrast underscores the high observed utilization rates. Although the retrospective 12-month window used in this survey may contribute to high rates by encouraging participation from those with recent healthcare contact, the main driver is clearly seen in the specific medical and psychological needs of TNB individuals.

These high utilization rates are likely driven by medical transition needs. Indeed, a significant portion of the respondents is either planning a medical transition (19%) or currently undergoing transition (40%), a process necessitating high engagement with the healthcare system. The inherent challenges and psychological distress associated with navigating both the medical and social transition processes likely contribute substantially to the high demand for mental health treatments. This is consistent with literature demonstrating that stressful events during transition are related to adverse mental health outcomes, including diagnoses and comorbidities[40]. Since a formal diagnosis of gender incongruence and subsequent psychiatric indication are typically required by health insurers and surgeons for various steps of medical transition, this necessitates high engagement with both psychologists and psychiatrists. The high rate of primary care use is likely influenced by policy requirement and the required referral coordination role of primary care providers, who must issue referrals to gain access to psychotherapy conducted by psychologists. This further supports the observed higher proportion of treatment by psychologists (65% vs. 50% in the norm population). Similarly, the high usage of specialized care is essential not only for transition-related procedures but also for required long-term follow-up, such as yearly control visits with endocrinologists for hormonal prescriptions and blood value monitoring.

Second, high healthcare use is likely sustained by the mental health impact of gender minority stress. Even participants who have finished medical transition or de-transitioned (23%) remain vulnerable to gender minority stress[36], which is associated with lower mental health and social functioning[36, 40-42].

These high utilization rates can also be driven by the respondents' low overall subjective health status. Only 63% reported good, very good, or excellent health compared to 85% in the Swiss norm population. While this low subjective health can be related to gender minority stress[36] and signals a higher overall disease or stress burden[40], it is important to note the contrast with findings from a large US trans health study[43]. They reported a much higher rate of good to excellent subjective health at 89% for trans individuals, a figure about 25 percentage points higher than that observed in this study's respondents. This significant difference suggests that systemic or contextual factors may worsen health challenges for Swiss TNB population. These factors may operate through mechanisms of suboptimal transition-related healthcare quality and ongoing gender minority stress. The resulting higher disease and stress burden, coupled with the need for specialized care, appears to be primarily driven by two key factors: medical transition needs and the mental health impact of structural stigma and gender minority stress encountered both within the healthcare system and broader society.

Despite these high usage rates, a significant number of participants reported **avoiding or delaying necessary care**, demonstrating a conflict between high medical needs and high avoidance. Specifically, 41% of the respondents reported having avoided or delayed healthcare at least once in the last 12 months, due to fear of sex/gender-related discrimination. The avoidance/delay rate in our study is nearly double the rate (23%) reported by a large US trans health study[43]. Furthermore, this barrier was not the same across all identity groups, as individuals in the multiple gender group (71%) and those identifying as non-binary (41%) reported significantly higher rates of avoidance or delay compared to those identifying as woman (32%) and man (27%). The extent of these significant differences across identity groups was not observed in the same extent in the study by Kcomt et al.[43]. This further highlights the vulnerability of certain subgroups within the Swiss context and is also alarming when comparing against national Swiss data: the 41% avoidance/delay rate in our study represents a substantial access barrier nearly six times higher than the 7% reported for the Swiss cis population, and is considerably higher than the 36% rate reported for trans individuals in a national Swiss survey[44].

Fear of discrimination may serve as a major factor in the avoidance/delay of necessary care. Among participants reported having delayed or avoided care, the top reported reasons were fear of gender-related discrimination (63%), followed by lack of qualified providers (48%), and past negative experiences (45%). The finding that nearly two-thirds delayed or avoided care due to fear of discrimination is notably higher than rates reported in the US. For instance, Kachen and Pharr[45] reported considerably lower rates of 31% for fear of discrimination. This difference indicates that this specific barrier may be more intense or prevalent within the Swiss context than in the US one. Interestingly, our respondents also reported slightly higher rates for cost reasons (35% vs. 30% in the US cohort by Kachen and Pharr). This disparity is noteworthy as healthcare insurance is mandatory in Switzerland, whereas the US cohort reported only 84% coverage. A potential explanation for this persistent financial barrier could be the high deductible (franchise) that insured individuals in Switzerland must pay out-of-pocket before insurance coverage begins. Furthermore,

Swiss health insurance usually does not cover treatments in foreign countries, which becomes a significant financial burden because a substantial percentage of facial feminization surgery and bottom surgeries are reportedly sought outside Switzerland (based on information from peer-support networks). This suggests that high out-of-pocket costs, rather than lack of insurance, constitute a primary financial barrier for this population.

These findings (the high rate of care delay and avoidance driven by fear of discrimination, provider gaps, and negative experiences) underscore the need to look beyond use rates and focus on the quality of care provided.

4.2 Experiences

4.2.1 At the structural level

The **accuracy of sex/gender-related information** in written communication and medical documents was only 'occasionally' to 'frequently' correct according to participants. Large statistically significant differences were found across gender identities: women and men rated sex/gender accuracy more frequently than non-binary individuals. These challenges were also highly context-dependent: accuracy was significantly better in settings where TNB individuals primarily receive gender-affirming care (e.g., with psychologists and other specialized providers) than in other contexts. For instance, overall accuracy was only seldom to occasionally correct when dealing with insurance providers, in non-gender specialized care settings, and in emergency departments. Substantially lower accuracy was reported by non-binary individuals for most settings, particularly with insurance providers (never to seldom correct).

A reason for this difference in accuracy may be that gender-affirming care clinics are more likely to adopt gender-inclusive forms as a high percentage of their patients are TNB, compared to the ER where most patients are not TNB and the lack of policy in Switzerland to mandate the collection of gender identity data. In contrast, the US has implemented policies. However, an evaluation in 2020 following the ACA's Meaningful Use Stage 3 requirements revealed that only 24% of Medicaid EHRs had the gender identity field completed[16]. Moreover, low accuracy was also reported in the US[16], with significant rates of data change, even for legal sex, reflecting potential entry errors or poor data exchange rather than just clinical context[6]. They also reported a significant lack of completeness in sex/gender-related data fields for patients potentially identifying as trans. While 100% of these patients had the legal sex field completed, less than half had the fields for ASAB (49%) and gender identity (48%) completed[6].

Beyond system capability, willingness to disclose is crucial: while the use of correct and accurate sex/gender data is central for affirmation, patients may refuse to disclose sex/gender-related information as a self-protective strategy against discrimination, stigmatization, or concerns about insurance coverage, especially concerning non-binary identities[1, 46]. The decision to disclose is a complex process influenced by many factors. Friley & Venetis[47] identified the patient's assessment of expected stigma, their ability to "pass" (i.e., be perceived as cisgender), and the relevance of the treatment to their gender identity as key factors. These findings were further confirmed by a large

quantitative European study by Falck & Bränström[48], which showed a strong relationship between experienced stigma in healthcare and the non-disclosure of gender identity. Additionally, research by Ogden et al.[49] found that a patient's trust in and comfort with the provider also remains a crucial factor influencing their decision to disclose sex/gender-related data. This complexity highlights that achieving affirmation requires not only accurate documentation but also an environment built on trust and reduced stigma to facilitate voluntary disclosure. This necessitates the implementation of inclusive data collection processes and medical forms that respect patient autonomy and choice.

The **inclusivity of sex/gender attributes** in forms were rated 'seldom' to 'occasionally' inclusive. These results demonstrate that non-inclusive options in data collection processes are a significant source of inaccurate data. Considerable differences were found across gender identities: non-binary individuals and those of the multiple gender group reported particularly low levels of inclusive options, rating them often as seldom inclusive. Significant differences were also observed across the healthcare context, underscoring systemic shortcomings. Specifically, non-binary individuals reported receiving 'never' to 'seldom' inclusive options in emergency care and from insurance providers, while the multiple gender group reported similarly low inclusivity with insurance providers. These findings reflect how current EMR systems likely model sex/gender-related data, reproducing cultural norms of a binary gender understanding and associating a person with only a single gender identity[50]. This is supported by item-level data, which showed that the correct use of a participant's name was reported more often than the correct use of honorifics or pronouns, indicating that simple, mandated identifiers are handled better than nuanced, affirming interpersonal attributes.

The conflict between patient needs and current limitations is described by literature on data collection preferences. Dunne et al.[5] investigated what sex/gender data should be collected and found that while healthcare professionals generally agreed with TNB patients on the need for pronouns, preferred name, and gender identity, they disagreed regarding the options provided for gender identity and the necessity to mandatorily collect ASAB. TNB individuals preferred more nuanced options and the ability to choose whether to disclose ASAB or not, emphasizing the need for control over who can access which information. Conversely, professionals indicated that ASAB is a crucial piece of information for primary care. The low inclusivity regarding options provided for sex/gender attributes found in our study confirms that the preferences for nuanced, non-binary, and autonomous data collection have not been implemented across the Swiss healthcare system.

Deficits were also registered regarding the **processes to change sex/gender-related data** in providers' systems. Overall, TNB individuals reported that it was difficult to change their sex/gender data. Stark differences were found across gender identities, again highlighting the impact of binary norms on administrative processes: binary trans individuals reported that it was relatively easy to change their data, whereas non-binary individuals experienced it as difficult to very difficult. This pattern underscores how strongly the cultural norms of a binary gender concept impact administrative processes. However, the observed difference across provider types suggests another specific issue: psychologists received higher ratings regarding the ease of data change compared to both psychiatrists and physicians. This variance suggests that the difficulty experienced by patients may stem from differences in professional competency across these groups. It potentially points toward a relative deficit in sociological and cultural knowledge and awareness regarding gender diversity among medical specialists (physicians and psychiatrists), which likely contributes to the

greater administrative difficulty and non-affirmation reported by TNB patients, especially those with non-binary identities. A more profound understanding of how potential deficits in provider competence and knowledge impact patient experiences is critical for improving quality of care, a topic explored further in the following section.

Regarding **providers' TNB-healthcare related knowledge**, TNB individuals rated their providers' knowledge as 'somewhat' to 'well informed' across all four assessed categories: inclusive communication, TNB mental health, TNB physical health and social aspects. Significant differences in perceived knowledge were consistently observed across gender identities, with binary trans individuals reporting substantially higher levels of provider knowledge. For example, female and male trans individuals rated providers as 'well' to 'very well' informed about communication, and 'well informed' about mental and physical health. Conversely, non-binary individuals reported significantly lower knowledge levels for physicians in all contexts outside of gender clinics and primary care, rating their knowledge in the communication, mental, and social categories as being between 'not very informed' to 'somewhat informed'. This demonstrates that provider knowledge appears to align more closely with binary gender identity constructs, possibly reflecting shortcomings of medical education and implicit bias.

Stark and substantial differences were found when comparing healthcare professional groups. Psychologists were consistently rated higher than both psychiatrists and physicians across nearly all knowledge categories. The only exceptions to this trend were observed among physicians in gender clinics, who achieved similar high scores for communication and the highest scores for physical TNB health. In contrast, low ratings were achieved by physicians in non-specialized settings, most notably in emergency departments, consistently ranked lower across all knowledge categories. This overall pattern suggests that specialized knowledge (held by psychologists and gender-clinic physicians) significantly improves the quality of the patient-provider interaction, while general practitioners and non-specialized settings often have limited necessary knowledge, which negatively impacts the patient-provider interaction and hinders patients' ability to feel safe and understood in this interaction and to build trust in the treatment.

Our findings are echoed internationally. For instance, a large US study reported that only 25% of patients felt their clinician knew "almost everything" about transgender care, while 31% were "unsure"[51]. Furthermore, a US university survey found that 90% of medical students reported only a "low" or "intermediate" knowledge level regarding the medical or nutritional management of patients with gender dysphoria[52]. These identified shortcomings in trans-related education and training are critical, as specialized training is essential to raise awareness among healthcare professionals for TNB needs, to increase their TNB-related knowledge and competency and to improve their confidence to work with TNB patients[53]. The low ratings for non-specialized physicians, particularly in emergency departments, indicate a significant and potentially dangerous knowledge gap in primary and acute care settings. This lack of broad foundational knowledge and competency directly contributes to the administrative difficulties and challenges in patient-provider interaction discussed previously. This knowledge deficit, however, may not be simply a matter of insufficient training; research demonstrates that providers' transphobia, rather than the amount of education received, is a stronger predictor of poor knowledge of transgender healthcare[54]. This finding is crucial as it indicates that gaps in understanding and awareness among providers can hinder the effective integration and application of clinical knowledge. While

educational interventions have shown positive short-term effects on student knowledge, skills, and confidence, future research must focus on collecting long-term data to ensure lasting improvements[55].

4.2.2 At the interpersonal level

Regarding **respectful communication**, our findings showed that trans men experienced significantly more inclusive language than trans women, non-binary, and multiple-gender individuals. The results also highlighted a significant disparity across gender identities in the experience of respectful communication within healthcare settings. Trans women and men generally reported experiencing respectful communication with healthcare professionals 'frequently' to 'very frequently' across most clinical settings. This suggests that for binary trans individuals, many healthcare providers are effectively employing respectful language. However, a marked contrast was observed when examining non-binary individuals and those of the multiple-gender group. These groups reported significantly less frequent experiences, citing respectful communication as occurring 'occasionally' to 'frequently'. This indicates that healthcare professionals appear to have greater difficulty using respectful language when communicating with individuals whose gender identity differs from the traditional binary. This lack of respect is a major barrier to care; Berrian et al.[56] reported that misgendering was one of the most mentioned barriers to quality healthcare among TNB individuals, emphasizing the critical importance of inclusive language for patient well-being and access. This aligns with the qualitative findings of Matsuno et al.[57], who described how non-binary individuals experience gender minority stressors, particularly misgendering, differently and more prominently than binary trans individuals. The frequent occurrence of misgendering among non-binary individuals has also been quantitatively confirmed in other research, such as the Canadian study by Jacobsen et al.[58].

Further analysis revealed differences in the experience of respectful language based on both gender identity and clinical setting. While trans men reported 'frequent' to 'very frequent' respectful language across all settings, trans women experienced this only 'occasionally' to 'frequently' in specialized care outside of gender clinics. The results for non-binary individuals were particularly concerning, suggesting significant gaps in competent communication across various specialties. Non-binary individuals reported only occasional use of respectful language by physicians in hospitals and specialized care outside gender clinics as well as psychiatrists, and even seldom to occasionally by physicians in emergency departments. These critical findings are in concordance with our study's results, which reported low ratings for providers' knowledge about physical and mental TNB health, communication, and social aspects for these specific categories of healthcare professionals. This documented lack of knowledge may directly translate to a lower awareness of the importance of inclusive language, which in turn contributes to experiences like misgendering that have a critical impact on patients' health and well-being[58]. Systemic changes are necessary to address these deficits. For example, the study by Chang et al.[59], which evaluated the incidence of misgendering throughout the perioperative experience for patients undergoing gender-affirming surgery, found that the introduction of preferred name and gender identity fields in the EMR was associated with a qualitative improvement for a more inclusive perioperative care experience for the majority of trans patients. This illustrates the powerful effect of simple, structural modifications in supporting consistent, respectful communication in the healthcare environment.

Moving beyond specific language use, the results for **perceived rejection** and **breach of confidentiality** reveal a generally more positive experience. Most TNB individuals reported feeling 'seldom' to 'never' rejected or unwelcomed by healthcare professionals, and breach of confidentiality was seldom experienced. Only small differences were observed across gender identities for gender-related rejection, with a minor effect size. This contrasts with the significant differences found for inclusive language and is consistent with external findings like Jäggi et al.[36], who found no significant differences in rejection among gender identities. However, this positive trend is contrasted with the concerning **frequency of harm**. Only 21% of TNB individuals reported never experiencing harm in healthcare within the last 12 months, meaning nearly 77% experienced it at least once. The harm rates found here should be interpreted as high, since other studies, such as the Swiss national survey by Krüger et al.[44] reported 32% experienced violence or discrimination (using a wider definition).

4.2.3 At the individual level

The experience of receiving care is not solely determined by provider actions but is heavily influenced by the individual patient's assessment and internal state. This section examines factors related to the patient's subjective appraisal of risk, such as disclosure safety, and negative expectations.

A key aspect of the individual experience is the subjective **sense of safety** when sharing sensitive identity information. TNB individuals generally felt 'neutral' to 'moderately' safe to disclose their sex/gender related information. Unlike the low frequency of rejection or confidentiality breaches observed previously, differences were found among gender identities and across the various healthcare contexts regarding safety perception. Specifically, binary trans individuals felt moderately safe, whereas non-binary and those of the multiple-gender group reported only neutral safety.

These disparities in perceived safety showed high correlations with providers' knowledge about respectful communication and social aspects of TNB care. This would suggest that patients' willingness to disclose is not simply based on avoiding active harm (like rejection) but on a self-proactive assessment of provider competence; trust is built where perceived social and communication knowledge is high. These findings support the general premise established by Hershberger et al.[60], whose work on psychological safety emphasized the importance of relationship comfort and a belonging atmosphere for patient disclosure. Indeed, the factors contributing to a belonging and welcoming atmosphere showed strong positive correlations with gender identity in this study: respectful communication (r = 0.70), form inclusivity (r = 0.50), sex/gender accuracy (r = 0.49), and sex/gender-related rejection (r = −0.46). However, the data also highlighted unique factors crucial for TNB patients that extend beyond Hershberger et al.'s work[60], specifically providers' specialized TNB knowledge. Patients' perceptions of provider knowledge across various domains were strongly correlated with feeling safe: social aspects (r = 0.67), inclusive communication (r = 0.66), TNB mental health (r = 0.58), and TNB physical health (r = 0.53). This suggests that patients feel safe to disclose their identity not only when they are treated respectfully and find inclusive data management implemented, but also when they perceive their providers to

be informed about their medical and psychological care and related medical needs as well as their life realities.

The necessity for patients to make such a proactive assessment of provider competences directly informs the next factor: the adoption of protective behaviors intended to manage the risk of **disclosing one's identity**. Regarding statements about changing behavior to avoid disclosure in medical contexts, TNB individuals reported 'somewhat disagreeing' to 'neither agreeing nor disagreeing' with most statements about changing their behavior. The statement they agreed with most strongly was, "I modify my way of speaking with healthcare professionals". This suggests that while outright avoidance of disclosure may not be universal, modifying speech or what they tell is a common self-protective strategy. No overall differences were found among gender identities for these behavior changes, a finding consistent with Jäggi et al.[36] in their Swiss cohort.

A significant individual factor relating to anticipation of harm is **negative expectations** regarding EMR documentation. The most negative expectation reported was that documenting their gender history in the EMR could increase their risk of experiencing discrimination or harassment within the healthcare setting. TNB individuals somewhat to strongly agreed with that statement. The second most reported concern was that documentation could lead to limitations in health insurance coverage, with respondents reporting somewhat agreeing with this statement. These findings indicate a high degree of distrust regarding data security and administrative fairness, suggesting that even when overt rejection is rare, the potential for systemic consequence (discrimination or financial penalty) is an important concern for TNB patients. The results revealed consistent agreement across gender identities regarding these negative expectations, highlighting a widespread, foundational concern that affects the entire TNB population.

4.3 Preferences and Suggestions

Participants showed a clear preference for written rather than oral collection of sex- and gender-related information. Assigned sex at birth and legal gender were the attributes most frequently preferred not to be collected at all (35% and 30%, respectively). More clinically oriented information, such as organ inventory, hormonal status, and medical (de-)transition, also met some resistance, with 11–17% of participants opposing their collection, indicating sensitivity even when medical relevance exists.

Preferences regarding access to sex- and gender-related information varied strongly by information type and professional role. Communication-related information (e.g. pronouns, used name, honorifics) was broadly supported for access by all healthcare personnel, with consistently high approval rates (>87%). In contrast, identity- and administrative information was more restricted, particularly ASAB, which very few participants were willing to share with front desk staff. The most restrictive preferences concerned medical-related information, which participants viewed as highly sensitive and primarily appropriate for physicians, with front desk workers consistently ranked as least appropriate recipients. Overall, participants favored controlled, role-based access, especially for sensitive medical data.

When asked to rank priorities for improving healthcare services, participants overwhelmingly identified increasing providers' knowledge of DTNBI-related needs as the top priority, reflecting a major perceived competence gap. This was followed by the need for greater provider comfort with DTNBI patients and more inclusive policies and administrative forms. Creating a welcoming clinical environment, improving communication skills, and better addressing DTNBI-specific healthcare needs followed closely behind. Expanding DTNBI-specific medical services alone ranked lowest, suggesting that participants prioritize foundational improvements in knowledge, comfort, and inclusivity over service expansion.

4.4 Limitations and Future Research

The design of this study has several inherent limitations. Firstly, its cross-sectional design prevents establishing causal relationships. While associations are robustly examined, the design cannot prove, for example, that structural barriers directly cause delays in seeking healthcare. Answering this kind of question requires an experimental design. Furthermore, retrospectively asking participants to report on experiences over the past 12 months, introduces a risk of recall bias: memory of past events may be inaccurate or biased. Thirdly, sampling limitations may affect generalizability of the findings. The non-probability recruitment via online and community channels introduces self-selection bias, meaning our respondents may not fully be representative for the TNB population in Switzerland. This likely results in an over-representation of individuals with recent, highly salient adverse healthcare experiences, potentially inflating reported barrier prevalence. Furthermore, offering survey exclusively in digital form may exclude less technologically engaged or older TNB individuals, introducing a sampling frame bias[61], potentially limiting the generalizability of findings to the entire TNB population. Finally, the study is subject to nonresponse and attrition biases, as the survey length (30 minutes) may have disproportionately excluded participants with lower cognitive tolerance or co-occurring health conditions.

Future research should aim at validating the findings with a larger sample group to improve statistical reliability, and to explore the nuance in subgroups. Finally, research should move beyond patient self-report to incorporate provider-level perspectives and objective data from EMRs. This is essential for developing system-level metrics to measuring both structural factors and improvements in health access outcomes, such as reduced healthcare avoidance rates.

5 Conclusions

The main objective was to investigate the experience of currently implemented policies regarding sex/gender documentation in EMRs. Drawing on data from 156 TNB participants, the consistent finding that non-binary individuals face significantly greater challenges across all measured structural and interpersonal domains highlights a critical disparity requiring targeted intervention. Addressing healthcare inequities for this population therefore necessitates not only mandating inclusive, non-binary-affirmative data collection policies and eliminating knowledge gaps in emergency and acute care settings, but also actively foster an environment of trust to reduce negative expectations.

The findings also show that the Swiss healthcare system currently generates a paradoxical pattern: exceptionally high healthcare utilization, driven by transition-related care and mental health needs, coexists with equally high healthcare avoidance. Specifically, 41% of participants avoided or delayed care, mostly due to fear of gender-related discrimination, a rate almost six times higher than in the Swiss cis population[38, 39] and substantially higher than comparable international studies.

This study also shows that structural factors - particularly inaccurate and non-inclusive EMR documentation, low inclusivity of forms, and administrative difficulty in updating sex/gender attributes - combine with interpersonal factors, including inconsistent respectful communication and insufficient provider knowledge, likely produce negative expectations. These negative expectations emerge as a key psychological mechanism linking structural stigma to healthcare avoidance, aligning strongly with the Gender Minority Stress and Resilience Model. Across all measured domains, non-binary individuals consistently reported the lowest levels of accuracy, inclusivity, provider knowledge, and safety, indicating a markedly disproportionate burden within this population.

Improving healthcare equity for TNB individuals in Switzerland requires coordinated interventions at the structural, interpersonal, and individual level. Structural reforms should mandate inclusive, non-binary-affirming EMR fields, ensure interoperability, and give patients greater control over their identity data. Interpersonally, healthcare providers, especially in emergency and acute care, should receive targeted training to close documented knowledge gaps and support gender-affirming, respectful communication. Finally, system-level reforms should explicitly aim to reduce negative expectations and strengthen trust at the individual level, ensuring that TNB individuals can access care without fear of administrative errors, discrimination, or misgendering. Only by addressing these structural, interpersonal, and individual dimensions together can the Swiss healthcare system meaningfully improve the inclusivity of health care and promote equitable access for the full diversity of TNB people.

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7 Appendices

7.1 Tables

Table 1 Distribution of ASAB, Intersex, Legal Gender, and Transition State Across Gender Identities

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Overall population	156	100	31	19.9	26	16.7	78	50.00	21	13.5
Assign Sex At Birth (ASAB)										
Female	105	68.2	0		26	100.00	65	84.4	14	66.7
Male	48	31.2	30	100.00	0		11	14.3	7	33.3
Other	1	0.6	0		0		1	1.3	0	
Intersex										
Yes	4	2.6	2	6.5	0		2	2.6	0	0
Legal gender										
Female	98	63.6	23	76.7	5	19.2	58	75.3	12	57.1
Male	49	31.8	7	23.3	21	80.8	14	18.2	7	33.3
Other	7	4.6	0		0		5	6.5	2	9.5
Transition state										
No plans	22	17.2	0		0		20	29.8	2	11.1
Transition planed	25	19.4	2	7.4	1	5.9	19	28.4	3	16.7
Transition started	52	40.3	21	77.8	8	47.1	16	23.9	7	38.9
Transition finished	28	21.7	3	11.1	8	47.1	11	16.4	6	33.3

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Detransition planed	1	0.8	0		0		1	1.5	0	
Detransition finished	1	0.8	1	3.7	0		0		0	

Note: Overall column shows the distribution of the full sample (n and %). Gender-identity columns show within-group percentages (column %) together with the corresponding counts (n). Percentages sum vertically within each gender-identity group.

Table 2 Distribution of Age, Education, Financial Strain, and Subjective Health Across Gender Identities

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Age (years)										
14 – 17	4	2.6	0		2	7.7	1	1.3	1	4.8
18 – 24	44	28.2	10	32.3	14	53.8	17	21.8	3	14.3
25 – 44	85	54.5	12	38.7	8	30.8	48	61.5	17	80.9
45+	23	14.7	9	29.0	2	7.7	12	15.4	0	
Education										
Compulsory	13	8.3	4	12.9	4	15.4	4	5.1	1	4.8
Upper secondary	44	28.2	7	22.6	11	42.3	23	29.5	3	14.3
Tertiary	99	63.5	20	64.5	11	42.3	51	5.1	17	81.0
Financial strain										
Yes	37	23.7	9	29.0	2	7.7	23	29.5	3	14.3
No	112	71.8	21	67.7	22	84.6	51	65.4	18	85.7
Prefer not to say	7	4.5	1	3.2	2	3.2	4	5.1	0	
Subjective health										
Excellent	9	5.8	2	6.4	2	7.7	3	3.8	2	9.5

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Very good	27	17.3	9	29.0	5	19.2	7	9.0	6	28.6
Good	62	39.7	15	48.4	9	34.6	35	44.9	3	14.3
Fair	46	29.5	5	16.1	10	38.5	25	32.0	6	28.6
Poor	12	7.7	0		0		8	10.3	4	19.0

Note: Overall column shows the distribution of the full sample (n and %). Gender-identity columns show within-group percentages (column %) and counts (n), summing vertically to 100% within each group. “Prefer not to say” is listed with its count but excluded from percentage totals.

Table 3 Distribution of Healthcare Use in the Last 12 Months across Gender Identities

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Primary care	137	91.3	29	93.5	19	79.2	69	93.2	20	95.2
Specialized care	135	88.2	28	90.3	23	92.0	65	85.5	19	90.5
Emergency department	43	28.7	8	25.8	5	20.0	26	35.1	4	20.0
Hospital stays	33	21.7	5	17.2	10	38.5	15	19.7	3	14.3
Mental health	134	86.4	27	87.1	24	92.3	64	83.1	19	90.5

Note: The Overall column shows the number and percentage of the full sample who used each healthcare service in the past 12 months. Gender-identity columns show the number of users and the usage rate within each gender-identity group (column %).

Table 4 Distribution of Avoiding/Delaying Healthcare and Reasons for Avoidance Across Gender Identities

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Avoiding or delaying healthcare										
Yes	63	40.9	10	32.3	7	26.9	31	40.8	15	71.4
Reasons for avoiding or delaying healthcare										
Fear of gender discrimination	99	63.5	18	58.1	15	61.5	48	61.5	17	80.9
Lack of qualified providers	75	48.1	12	38.7	11	42.3	41	51.6	11	52.4
Past negative experience	71	45.5	7	22.6	7	28.0	43	54.4	14	66.7
Self-management	59	37.8	10	32.3	12	46.1	31	39.7	6	28.6
Cost concerns	55	35.3	14	45.2	7	26.9	26	33.3	8	38.1
Symptoms will resolve	52	33.3	8	25.8	10	38.5	30	38.5	4	19.0
Lack of time	44	28.2	6	19.4	5	19.2	23	29.5	10	47.6
Treatment uselessness	31	19.9	6	19.4	2	7.7	17	21.8	6	28.6
Fear of treatment	29	18.6	6	19.4	3	11.5	17	21.8	3	14.3
Confidentiality concerns	25	16.0	6	19.4	4	15.4	14	17.9	1	4.8

Note: Within-group percentages (column %) plus counts (n), summing vertically within each identity group.

Table 5 **Distribution of Sex/Gender Accuracy, Form Inclusiveness, and Ease of Change Across Healthcare Settings and Gender Identities (Structural level)**

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Sex/gender accuracy										
Overall	3.76	1.32	4.54	0.86	4.6	0.84	3.2	1.32	3.55	1.3
Primary care	3.53	1.57	4.36	1.14	4.58	1.11	2.97	1.56	3.29	1.6
Specialized care	3.60	1.55	4.51	1.05	4.34	1.15	2.88	1.6	3.26	1.50
Gender clinic	4.13	1.24	4.74	0.71	4.5	0.8	3.01	1.4	3.61	1.51
Non-gender clinic	2.88	1.67	3.00	1.80	3.67	2.31	2.81	1.70	2.70	1.45
Emergency care	2.79	1.80	4.04	1.65	n<3	-	2.23	1.54	n<3	-
Inpatient care	3.50	1.76	4.00	2.00	4.56	1.5	2.25	1.49	n<3	-
Mental health care	4.48	1.03	4.81	0.41	4.92	0.26	4.18	1.28	4.39	1.09
Psychiatrist	4.15	1.25	4.75	0.53	4.84	0.37	3.21	1.62	4.28	0.67
Psychologist	4.63	0.89	4.85	0.31	5.00	0.00	4.50	0.98	4.44	1.26
Insurance provider	2.97	1.74	4.42	1.26	3.83	1.62	1.94	1.27	2.95	1.74
Form inclusivity										
Overall	2.72	1.34	3.74	1.24	3.58	1.37	2.24	1.12	2.13	0.88
Primary care	2.42	1.42	3.23	1.52	3.37	1.56	2.15	1.28	1.64	0.64
Specialized care	2.66	1.47	3.79	1.33	3.4	1.56	2.1	1.2	2.02	0.99
Gender clinic	3.40	1.36	4.02	1.20	3.9	1.4	2.7	1.2	2.42	0.79
Non-gender clinic	1.82	1.10	2.50	1.50	1.87	0.99	1.78	1.11	1.62	1.08
Emergency care	1.77	1.16	2.83	1.84	n<3	-	1.37	0.39	n<3	-
Inpatient care	2.7	1.6	3.11	1.65	3.7	1.65	1.68	1.09	n<3	-
Mental health care	3.43	1.48	4.37	0.91	4.18	1.1	2.90	1.525	3.07	1.51

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Psychiatrist	3.44	1.56	4.82	0.28	4.44	0.96	2.63	1.51	n<3	-
Psychologist	3.46	1.45	4.17	1.04	4.26	1.00	3.00	1.52	3.38	1.54
Insurance provider	2.00	1.37	3.07	1.65	2.9	1.74	1.41	0.63	1.55	0.97
Ease of change										
Overall	3.21	1.42	4.28	0.78	4.29	1.16	2.45	1.26	3.24	0.93
Primary care	3.4	1.46	4.07	1.08	4.84	0.35	2.7	1.4	3.11	1.26
Specialized care	3.23	1.51	4.16	0.83	4.34	1.35	2.16	1.24	3.40	1.00
Gender clinic	3.74	1.5	4.50	0.45	4.2	1.47	2.00	1.44	3.87	0.99
Non-gender clinic	2.63	1.31	n<3	-	n<3	-	2.23	1.20	2.93	0.95
Inpatient care	3.11	1.50	3.10	0.99	4.04	1.65	1.90	0.71	2.00	0.57
Mental health care	3.31	1.45	4.56	0.73	4.09	1.42	2.65	1.33	3.70	1.06
Psychiatrist	3.04	1.64	4.40	0.89	4.50	0.71	1.91	1.32	n<3	-
Psychologist	3.53	1.37	4.75	0.50	4.13	1.68	3.04	1.25	3.76	1.18
Insurance provider	3.19	1.63	4.04	0.94	4.41	1.02	1.97	1.47	2.72	1.61

Note: The table presents the mean (*m*) and standard deviation (*sd*) for the three numeric scales (data accuracy, form inclusiveness, data change process inclusivity). Descriptive statistics are shown for the total respondents (Overall) and are broken down across gender identity subgroups for each healthcare setting. The mean and standard deviation are not reported (–) for categories with less than three respondents.

Table 6 Distribution of Providers' Knowledge Across Healthcare Settings and Gender Identities (Structural level)

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Provider knowledge of inclusive communication										
Overall	3.83	1.00	4.39	0.57	4.48	0.58	3.48	1.06	3.42	0.95
Primary care	3.67	1.20	4.32	0.65	4.36	0.6	3.45	1.34	2.58	0.93
Specialized care	3.79	1.19	4.46	0.66	4.63	0.40	3.22	1.27	3.54	1.14
Gender clinic	4.31	0.86	4.6	0.55	4.80	0.34	3.59	1.11	4.36	0.56
Non-gender clinic	3.05	1.21	3.50	0.50	4.17	0.29	3.00	1.33	2.40	0.55
Emergency care	2.50	1.47	4.17	0.82	n<3	-	1.60	0.81	n<3	-
Inpatient care	3.93	1.16	4.63	0.48	4.6	0.55	2.86	1.38	n<3	-
Mental health care	4.09	1.04	4.46	0.74	4.43	0.95	3.87	1.10	3.94	1.12
Psychiatrist	3.69	1.27	4.28	0.75	4.56	1.02	2.97	1.26	3.42	1.28
Psychologist	4.28	0.83	4.57	0.73	4.4	0.94	4.16	0.80	4.23	0.96
Provider knowledge of TNB mental health										
Overall	3.61	1.13	3.84	1.02	4.19	0.91	3.41	1.21	3.18	0.99
Primary care	3.22	1.21	3.29	0.99	3.9	0.88	3.23	1.39	2.40	0.84
Specialized care	3.42	1.31	4.11	0.96	4.07	1.00	2.83	1.39	3.00	1.10
Gender clinic	3.78	1.19	4.11	0.96	4.17	1.03	3.21	1.42	3.43	1.13
Non-gender clinic	2.53	1.17	n<3	-	n<3	-	2.47	1.30	2.25	0.50
Emergency care	2.80	1.48	4.25	0.96	n<3	-	2.00	0.82	n<3	-
Inpatient care	3.40	1.43	4.67	0.58	3.6	1.58	2.60	1.14	n<3	
Mental health care	4.04	1.19	3.96	1.22	4.69	0.67	3.86	1.21	3.93	1.39
Psychiatrist	3.53	1.39	3.44	1.33	4.67	0.71	2.93	1.44	3.33	1.37
Psychologist	4.32	0.99	4.29	1.07	4.78	0.67	4.21	0.93	4.33	1.32

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Provider knowledge of TNB physical health										
Overall	3.63	1.1	3.86	0.98	4.20	0.74	3.47	1.16	3.08	1.09
Primary care	3.34	1.20	3.53	0.9	3.77	1.01	3.45	1.36	2.23	0.85
Specialized care	3.93	1.15	4.41	0.83	4.56	0.73	3.5	1.28	3.54	1.1
Gender clinic	4.36	0.80	4.53	0.66	4.73	0.48	3.94	1.05	4.19	0.59
Non-gender clinic	3.12	1.30	n<3	-	3.83	1.26	3.17	1.36	2.25	0.50
Emergency care	2.65	1.34	4.33	1.16	n<3	-	2.13	0.99	n<3	-
Inpatient care	4.02	1.19	4.50	0.58	4.7	0.67	3.14	1.31	n<3	-
Mental health care	3.60	1.25	3.67	1.16	3.97	1.16	3.57	1.23	3.13	1.51
Psychiatrist	3.35	1.37	3.17	1.20	4.06	1.2	3.21	1.45	2.83	1.63
Psychologist	3.73	1.21	4.00	1.06	3.94	1.29	3.66	1.19	3.33	1.48
Provider knowledge of social aspects										
Overall	3.31	1.08	3.78	0.89	3.99	0.77	2.98	1.08	2.93	1.08
Primary care	2.93	1.27	3.58	0.93	3.54	1.02	2.71	1.34	2.04	1.07
Specialized care	3.13	1.23	3.8	1.07	3.86	0.75	2.63	1.2	3.1	1.1
Gender clinic	3.64	1.06	3.94	1.04	3.9	0.77	3.06	1.22	3.75	0.71
Non-gender clinic	2.50	1.13	3.00	1.00	3.67	0.76	2.40	1.16	2.10	0.82
Emergency care	2.09	1.13	3.25	1.25	n<3	-	1.62	0.74	n<3	-
Inpatient care	3.00	1.22	3.50	1.00	3.50	1.27	2.25	1.04	n<3	-
Mental health care	3.82	1.17	4.07	1.05	4.43	0.9	3.61	1.16	3.47	1.39
Psychiatrist	3.32	1.38	3.70	1.20	4.33	1.10	2.70	1.25	2.75	1.47
Psychologist	4.05	0.98	4.29	0.89	4.55	0.76	3.9	0.95	3.86	1.23

Note. The table presents the mean (*m*) and standard deviation (*sd*) for the four numeric scales detailing providers' knowledge. Descriptive statistics are shown for the total respondents (Overall) and are broken down across gender identity subgroups for each healthcare setting. The mean and standard deviation are not reported (–) for categories with less than three respondents.

Table 7 **Distribution of Respectful Communication, Perceived Rejection, and Breach of Confidentiality Across Healthcare Settings and Gender Identities (Interpersonal level)**

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Respectful communication										
Overall	3.79	1.17	4.46	0.66	4.65	0.58	3.26	1.20	3.62	1.10
Primary care	3.74	1.43	4.63	0.65	4.38	1.05	3.32	1.59	3.27	1.24
Specialized care	3.90	1.30	4.65	0.76	4.71	0.67	3.27	1.38	3.90	1.15
Gender clinic	4.52	0.76	4.82	0.40	4.79	0.55	3.91	1.03	4.54	0.40
Non-gender clinic	3.08	1.41	3.56	1.64	4.33	1.15	2.95	1.43	2.87	1.24
Emergency care	2.51	1.61	4.28	1.31	n<3	-	1.60	0.81	n<3	-
Inpatient care	3.86	1.37	4.00	1.59	4.63	0.62	2.98	1.54	n<3	-
Mental health care	4.43	0.97	4.68	0.62	4.90	0.27	4.13	1.15	4.51	0.94
Psychiatrist	3.94	1.33	4.56	0.83	4.96	0.11	2.97	1.33	3.92	1.41
Psychologist	4.66	0.60	4.76	0.44	4.83	0.36	4.53	0.74	4.83	0.32
Perceived rejection										
Overall	1.64	0.85	1.46	0.82	1.16	0.30	1.77	0.85	2.02	1.06
Primary care	1.53	1.02	1.28	0.58	1.21	0.58	1.61	1.08	1.93	1.44
Specialized care	1.67	1.03	1.39	0.84	1.19	0.75	1.81	1.02	2.23	1.30
Gender clinic	1.45	0.85	1.20	0.52	1.23	0.83	1.80	1.08	1.75	0.89
Non-gender clinic	1.95	1.16	2.67	1.53	1.00	0.00	1.82	1.01	3.00	1.58
Emergency care	2.05	1.21	1.50	1.23	n<3	-	2.58	1.16	n<3	-
Inpatient care	1.58	1.02	2.50	1.91	1.00	0.00	1.67	0.87	n<3	-
Mental health care	1.44	0.94	1.22	0.85	1.11	0.32	1.56	1.00	1.77	1.20
Psychiatrist	1.64	1.09	1.44	1.33	1.11	0.33	1.93	1.10	2.00	1.27
Psychologist	1.27	0.74	1.07	0.27	1.00	0.00	1.31	0.75	1.64	1.21

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Breach of confidentiality										
Overall	1.22	0.64	1.12	0.36	1.29	0.86	1.21	0.65	1.29	0.62
Primary care	1.22	0.76	1.40	1.12	1.00	0.00	1.15	0.54	1.42	1.16
Specialized care	1.12	0.54	1.00	0.00	1.00	0.00	1.26	0.82	1.11	0.33
Gender clinic	1.04	0.28	1.00	0.00	1.00	0.00	1.17	0.58	1.00	0.00
Non-gender clinic	1.26	0.81	1.00	0.00	1.00	0.00	1.32	0.95	n<3	-
Emergency care	1.22	0.55	1.20	0.45	n<3	-	1.30	0.67	n<3	-
Inpatient care	1.32	0.95	2.33	2.31	1.00	0.00	1.33	0.71	n<3	-
Mental health care	1.27	0.94	1.20	0.89	1.42	1.26	1.31	0.96	1.07	0.26
Psychiatrist	1.24	0.71	1.00	0.00	1.00	0.00	1.58	1.08	1.20	0.45
Psychologist	1.24	0.96	1.31	1.11	1.89	1.76	1.12	0.69	1.00	0.00

Note. The table presents the mean (*m*) and standard deviation (*sd*) for the four numeric scales. Descriptive statistics are shown for the total respondents (Overall) and are broken down across gender identity subgroups for each healthcare setting. The mean and standard deviation are not reported (–) for categories with less than three respondents.

Table 8 Distribution of Harm Across Gender Identities (Interpersonal level)

	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Very frequently	4	2.6	1	3.2	1	3.8	2	2.6	0	0.0
Frequently	14	9.0	4	12.9	1	3.8	6	7.8	3	14.3
Occasionally	54	34.8	12	38.7	9	34.6	24	31.1	9	42.9
Seldom	35	22.6	5	16.1	7	26.9	19	24.7	4	19.0
Never	33	21.3	6	19.3	8	30.8	14	18.2	5	23.8

Note: Within-group percentages (column %) plus counts (n), summing vertically within each identity group ('not applicable' answer not shown).

Table 9 Distribution of Disclosure Safety Across Healthcare Settings and Gender Identities (Individual level)

	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Overall	3.76	1.06	4.42	0.66	4.30	0.87	3.40	1.07	3.38	0.98
Primary care	3.76	1.29	4.56	0.51	4.27	0.88	3.55	1.46	3.07	1.00
Specialized care	4.03	1.25	4.82	0.40	4.80	0.40	3.60	1.42	3.42	1.00
Gender clinic	4.33	1.12	4.84	0.38	4.83	0.38	3.86	1.58	3.86	0.90
Non-gender clinic	3.68	1.30	4.67	0.58	4.67	0.58	3.64	1.36	2.80	0.84
Emergency care	2.56	1.28	4.17	0.75	n<3	-	1.94	1.00	n<3	-
Inpatient care	3.54	1.48	4.50	0.58	4.00	1.33	2.60	1.17	n<3	-
Mental health care	4.42	1.02	4.70	0.70	4.7	0.57	4.28	1.10	4.18	1.33
Psychiatrist	3.93	1.37	4.56	1.01	4.56	0.73	3.47	1.42	3.33	1.86
Psychologist	4.67	0.65	4.79	0.43	4.90	0.32	4.58	0.76	4.64	0.67

	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*	*m*	*sd*
Insurance provider	2.45	1.23	3.26	1.37	3.31	1.01	1.97	1.00	1.90	0.77

Note. The table presents the mean (*m*) and standard deviation (*sd*) for the the numeric scale. Descriptive statistics are shown for the total respondents (Overall) and are broken down across gender identity subgroups for each healthcare setting. The mean and standard deviation are not reported (–) for categories with one or fewer respondents.

Table 10 Distribution of Negative Expectations and Non-Disclosure Behavior Across Gender Identities (Individual level)

Variables	Overall n=156		Female n=31		Male n=26		Non-binary n=78		Multiple n=21	
	m	*sd*	*m*	*sd*	*m*	*sd*	*m*	*m*	*m*	*sd*
Negative expectations	22.42	7.33	20.97	8.40	20.46	7.36	22.92	7.03	24.95	6.13
Non-disclosure behavior	8.24	5.33	8.08	5.82	7.52	4.38	8.63	5.48	7.86	5.30

Note. The table presents the mean (*m*) and standard deviation (*sd*) for the two numeric scales. Descriptive statistics are shown for the total respondents (Overall) and are broken down across gender identity subgroups.

Table 11 Themes of positive experiences related to sex/gender identity or expression

Theme	Explanation	Key words	Quotes
Respectful Use of Names, Pronouns, and Gendered Address (Positive Affirmation)	Positive experiences where healthcare professionals asked about, respected, and correctly used patients' names, pronouns, and forms of address, often documenting them to avoid misgendering.	pronouns, name, address, misgendering, respect	"My surgeon for top surgery asked what my used name was and if it differs from my legal name and how i would label my gender. They made a comment in the data platform of the whole hospital about my used name and changed my gender." "Alle Ärzt:innen, bei denen ich mich outete, fragten respektvoll nach, wie sie mich ansprechen wollten, und vermerkten das auch in meinem Dossier zuhanden des Fachpersonals." "I like that most doctor's are very understanding of gender identity and they try to use correct pronouns and salutations. most of the doctors I went to do more than I requested to ensure I don't get misgendered."
Emotionally Supportive and Human-Centered Care Despite Limited Training	Experiences where professionals lacked formal training on trans issues but showed empathy, openness, humility, and a strong willingness to learn and provide respectful care.	empathy, openness, listening, learning, support	"Thérapeutes en santé mentale visiblement pas ou peu formés sur la transidentité, mais clairement ouverts, acceptants, non-jugeant." "Médecin généraliste très soutenant, absolument perdu et non-informé, mais déterminé à aider et faire de son mieux, à l'écoute et prêt à apprendre" "Des soignant•exs qui n'y connaissent pas grand chose, mais qui font plein d'effet pour respecter quand même, qui prennent l'initiative de se renseigner par iels mêmes pour être plus adéquat•exs"
Specialized and Gender-Affirming Healthcare as a Source of Safety and Trust	Positive experiences linked to specialized, professionals and services, which created strong feelings of safety, trust, and quality of care.	specialized care, queer, Checkpoint, expertise, safety	"Ich bin im Checkpoint Zürich in Behandlung und der Ort ist super inklusiv - alle Mitarbeitenden sind extrem gut informiert und respektvoll." "90% der positiven Erlebnissen waren mit Fachpersonen, die auf trans/queere Patient_innen spezialisiert sind (oder sogar selbst trans sind) und daher informiert und respektvoll waren." "Going to a hospital for Top surgery and really feeling/seeing that they have a lot of experience working with trans people."
Administrative Flexibility and Inclusive Systems (Relief and Recognition)	Positive experiences with administrative processes, forms, insurance, and IT systems that were adapted or flexibly handled to better respect gender diversity.	forms, administration, insurance, systems, documents	"anmeldeformulare mit 'divers'" "Im Rahmen der Psychotherapie hat es die Institution sogar geschafft, auf der offiziellen Rechnung für die Krankenkasse kein Geschlecht aufzuführen." "J'ai demandé à ma caisse maladie (KKV) d'éviter le 'Sehr geehrter Herr' au début des lettres en raison de ma non-binarité."
Affirming Access to Transition-Related Care Without Gatekeeping	Experiences of smooth, respectful access to transition-related healthcare (hormones, surgery, referrals) without	transition, hormones, surgery, referral, no gatekeeping	"I got my referral to the endocrinologist by my GP without any questions other than 'You want hormone treatment?'." "Insurance quickly agreed to cover costs of surgery related to transition." "Once treatments were approved they started quickly and were effective in reducing dysphoria."

Table 12 Themes of negative experiences related to sex/gender identity or expression

Theme	Explanation	Key words	Quotes
Misgendering, Deadnaming, and Disrespectful Forms of Address (Distress and Exhaustion)	Recurrent experiences of being misgendered, deadnamed, or addressed incorrectly, even after correction or legal changes, leading to feelings of invisibility, exhaustion, and lack of safety.	misgendering, deadname, pronouns, honorifics, name	"My usual experience when I try telling my preferred name and pronouns, is getting straight up ignored." "Misgendering und Verwendung meines - amtlich geänderten! - Deadnames durch ein grosses Spital, obwohl dieses die aktuellen Angaben hatte." "Que l'on me dise madame sans m'avoir demandé mon genre , d'avoir une lettre sur notre braselet à l'hôpital qui affiche clairement notre sex assigné à la naissance"
Intrusive, Inappropriate, and Dysphoria-Inducing Questions (Discomfort and Humiliation)	Healthcare professionals asking unnecessary, invasive, or dysphoria-triggering questions unrelated to care, often framed as curiosity or ignorance, causing discomfort and humiliation.	intrusive questions, dysphoria, curiosity, inappropriate, discomfort	"Gynécologue : questions indiscrètes." "healthcare practicioners asking me unneccessary and personal questions that are not related to the current issue" "Lors d'une prise de sang pour commencer un traitement hormonal (dans un centre de prélèvement), l'infirmière m'a posé pas mal de questions intrusives autour de ma transition (quel était mon deadname par exemple)."
Lack of Knowledge and Clinical Incompetence Regarding Trans Health (Frustration and Risk)	Insufficient or outdated medical knowledge on trans, non-binary, or intersex health leading to poor care, misdiagnosis, dismissal of symptoms, or unsafe treatment decisions.	lack of knowledge, incompetence, hormones, endocrinology, ignorance	"Incompetent endocrinologists" "les endocrinologues sont généralement extrêmement peu à jour sur les questions de traitements hormonaux de substitution transfems." "Die meisten Ärzt:innen sind überfordert mit der biologischen Realität meines (transitionerten) Körpers."
Gatekeeping, Pathologization, and Psychiatric Control (Powerlessness and Anger)	Experiences of excessive psychiatric requirements, pathologizing language, forced evaluations, or denial of care that frame trans identity as a disorder or choice.	gatekeeping, psychiatry, diagnosis, pathologization, control	"- obligation de consulter un psychiatre pour toutes démarche en lien avec mon identité." "Psychiatre pour l'attestation de dysphorie de genre transphobe, mise en doute du vécu" "The first doctor I came out to ... told me these thoughts typically go away and asked me to come back in 4 months"
Administrative and Systemic Barriers in a Binary Healthcare System (Fatigue and Exclusion)	Structural issues such as binary forms, outdated IT systems, insurance constraints, and inconsistent records that systematically exclude trans and non-binary people.	administration, forms, binary system, records, IT	"binäre formulare" "Ihre Systeme meine Daten aufzunehmen sind veraltet und lassen keine Non-Binärität zu." "Toute la question bureaucratique rend difficile tout changement du sexe attribué à la naissance."

Theme	Explanation	Key words	Quotes
Insurance Delays, Refusals, and Financial Gatekeeping (Stress and Injustice)	Repeated refusals, delays, or administrative obstruction by health insurance providers, resulting in postponed or denied access to transition-related care.	insurance, refusal, costs, delays, reimbursement	"Les assurances maladies sont un cauchemar, les dossiers trainent très longtemps, refus sur des prétextes fallacieux" "Meine Krankenkasse hat mir zweimal eine Geschlechtsangleichende Behandlung verwehrt" "Most of the time ... treatments were always dependent on professionals being very slow."
Breach of Confidentiality and Lack of Privacy (Fear and Unsafety)	Violations of medical confidentiality, forced outing, and public disclosure of sensitive information, leading to fear, loss of trust, and feelings of unsafety.	confidentiality, outing, privacy, disclosure, trust	"ruptures du secret médical" "outing forcé (j'ai demandé de faire un dossier, le professionnel en face a préférer recherche dans les dossiers existants et a trouvé mon ancienne identité)" "Mon deadname a été divulgué sans mon consentement par une médecin à d'autres de mes thérapeutes"
Discrimination, Transphobia, and Moral Judgment by Professionals (Harm and Invalidity)	Explicitly transphobic remarks, moral judgments, minimization of lived experience, or ideological positioning by healthcare professionals causing harm and invalidation.	discrimination, transphobia, judgment, invalidation, stigma	"also wenn mein Kind trans wäre, würde ich mich schon fragen, was ich als Vater falsch gemacht habe" "une personne noire n'a pas choisi d'être noire, vous avez fait le choix d'être trans" "elle s'est révélée être extrêmement transphobe et a comparé l'idée à de la mutilation."
Long Waiting Times and Delayed Access to Care (Hopelessness and Weariness)	Excessive waiting periods for appointments, treatments, or coordination between services, contributing to psychological distress and loss of trust.	waiting times, delays, access, coordination, exhaustion	"Long waiting periods for various treatments" "Die Wartezeiten für Hormontherapie bzw. Besprechungen für Mastektomie waren sehr lange" "Took 1.5 years to get hrt"
Emotional Burden, Fear of Disclosure, and Self-Censorship (Chronic Stress)	The cumulative emotional toll leading patients to hide their identity, avoid care, or remain silent to protect themselves from discrimination.	fear, anxiety, self-censorship, stress, avoidance	"Most of the time i don't say anything out of fear." "Few because I hide myself, don't come out to protect myself from such experience" "Je préfère etre megenré et non out c est moins épuisant"

Table 13 Themes of suggestions to make healthcare services more inclusive

Theme	Explanation	Key words	Quotes
Better Training and Awareness of DTNBI Realities (Need for Competence and Recognition)	Calls for improved initial and ongoing training of healthcare professionals to ensure awareness, clinical competence, and understanding of trans, non-binary, and intersex realities, including dysphoria and transition care.	training, awareness, education, dysphoria, competence	"Davantage de prévention. Actuellement, certaines personnes dans les services médicaux semblent ne même pas avoir conscience de l'existence des personnes trans" "-Intégrer des cours sur la question dans les formations de base des futur·e·x·s intervenant·e·x·s de la santé" "Surtout former les professionnel.le.x.s de santé à ces thématiques!"
Respectful, Patient-Centered Communication and Listening (Validation and Trust)	Emphasis on listening to patients, accepting their lived reality without questioning it, avoiding unnecessary inquiries, and centering care on patients' actual needs and contexts.	listening, respect, communication, trust, patient-centered	"Actually listening to patients about what they want" "Wahrheit einer Person als Wahrheit annehmen und nicht hinterfragen, nur wirklich nötige Infos abfragen" "If i have back pain, I don't want to talk about genitalia."
Inclusive Language and De-Gendered Medical Communication (Clarity and Safety)	Suggestions to reduce gendered language in favor of anatomically or physiologically precise terms, and to rethink problematic terminology that causes discomfort or exclusion.	language, terminology, anatomy, gendered language, communication	"favoring anatomically and/or physiologically specific references over gendered language" "Treat us normal as the gender we are, not the sex that cursed us." "I do not like the terms 'gender affirming care', 'gender identity' or 'identity', 'preferred' pronouns or name"
Inclusive Infrastructure and Hospital Practices (Safety and Dignity)	Concrete proposals to adapt physical spaces and care practices, such as gender-neutral toilets and respectful room placement during hospitalisation, to prevent outing and harm.	toilets, hospitalisation, rooms, infrastructure, safety	"Les services de santé pourraient être plus inclusifs par l'installation de toilettes neutres" "permettre au patient trans/non-binaire d'avoir son mot à dire concernant le placement en chambre" "On m'a répondu : ' Il n'y a pas de place pour les gens comme vous à l'hôpital '."
Administrative and IT Systems That Reflect Gender Diversity (Usability and Inclusion)	Calls for healthcare and insurance IT systems, forms, and records to allow non-binary options, differentiated data use, and easy updates to names and honorifics.	IT systems, forms, administration, non-binary, records	"Kliniminformationssysteme berücksichtigen meist nur Geschlecht und Vornamen auf der Krankenkassen-Karte" "dass es in den IT Systemen überhaupt erst möglich ist" "make it easier to change name/salutation on computer generated letter heads."
Transparency, Data Protection, and Control Over Personal Information (Security and Autonomy)	Strong demand for clarity about who accesses personal data, why information is collected, and how confidentiality is ensured, to reduce fear of outing and misuse.	data protection, transparency, confidentiality, control, privacy	"Limiter les droits d'accès aux dossier et améliorer la protection des données personnelles" "Appliquer le principe dit 'des moindres privilèges'" "Personen müssten sicher sein können, dass Angaben nicht missbräuchlich verwendet werden"

Theme	Explanation	Key words	Quotes
Clear Signals of Inclusion and Visible Affirmation (Reassurance and Belonging)	Importance of visible signs that signal inclusivity and safety (forms, symbols, pronoun sharing), reducing the burden of uncertainty and fear of coming out.	visibility, signals, inclusion, pronouns, safety	"Klar signalisieren, dass DTNBI Personen willkommen sind" "Inklusive Formulare, LGBTQ+ Flaggen/Flyer/Farben/Bilder können Inklusivität und Offenheit signalisieren." "If everyone displays their pronouns and salutation it normalizes it for us 'special cases'"
Easier and Non-Pathologizing Access to Transition-Related Care (Autonomy and Equity)	Requests to remove gatekeeping, psychiatric requirements, and insurance barriers, and to recognize transition-related care as essential medical care.	access, gatekeeping, insurance, autonomy, depathologization	"Dépsychiatrisation Formation du personnel de la santé" "que tous les soins (dé)transaffirmatifs soient pris en charge par l'assurance de base" "Accès libre aux hormones (médicaments en accès libre)"
Improved Coordination and Shared Responsibility in Transition Care (Continuity and Reliability)	Concerns about poor interdisciplinary coordination that shifts responsibility onto patients, with calls for better communication and shared accountability among providers.	coordination, responsibility, communication, transition care	"Especially interdisciplinary coordination and communication seems to be bad in healthcare in general" "I have to take over all the coordination and communication and hence also overall responsibility for my medical trans

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