

Attitudes of Medical Doctors and Experiences of Trans and Non-Binary People in the Greek Healthcare System: A Mixed Methods Approach

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abstract

Trans and non-binary individuals face significant barriers in accessing healthcare, often encountering discrimination, stigma, and a lack of competent medical support. While research in Europe has documented these challenges, data specific to Greece are scarce. This mixed-methods study investigates the attitudes of medical doctors toward trans and non-binary individuals in Greece and explores the lived experiences of these individuals within the Greek healthcare system. A quantitative survey of medical professionals (n=248) reveals that systemic cisnormative biases and insufficient gender-diversity training contribute to negative attitudes and unequal treatment of trans patients. Regression analyses indicate that medical professionals' attitudes are significantly influenced by gender, age, prior LGBTQ+ education, and personal contact with LGBTQ+ individuals. Qualitative interviews with trans and non-binary participants (n=20) highlight recurring themes of medical gatekeeping, misgendering, lack of informed consent, and emotional distress resulting from negative healthcare encounters. The findings underscore an urgent need for comprehensive medical education reform and policy changes to ensure equitable, affirming healthcare services for trans and non-binary people in Greece. This study contributes new data to fill the research gap in Greece and offers evidence-based recommendations to improve healthcare practices and policies for gender-diverse populations.

keywords

trans healthcare, non-binary individuals, medical discrimination, gender-affirming care, healthcare policy, LGBTQ+ rights, Greece, mixed-methods research

Introduction

Trans¹ and non-binary individuals continue to face systemic discrimination in many aspects of life, with healthcare being one of the most critical areas of concern. Across Europe and North America, research has documented widespread disparities in healthcare access, quality of treatment, and medical professionals' attitudes toward gender-diverse people (Bauer et al., 2015; Poteat et al., 2019). In Greece, however, this issue remains underexplored, empirical studies examining both the experiences of trans and non-binary patients and the attitudes of medical professionals are very limited (Voultsos et al., 2023). The absence of comprehensive research has left a policy vacuum, resulting in insufficient medical guidelines, a lack of structured training for healthcare providers, and inconsistent services for trans and non-binary individuals. Studies in other countries have shown that healthcare

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discrimination against trans people manifests in denial of care, refusal to acknowledge a patient's gender identity, and unnecessary medical gatekeeping that forces individuals to conform to cisnormative standards before receiving gender-affirming care (Reisner et al., 2015). Additionally, trans and non-binary patients frequently report psychological distress due to misgendering, invasive questioning and implicit biases among healthcare professionals (Bauer et al., 2014). While legislative advancements in some nations have improved healthcare accessibility for trans populations, Greece still lacks a standardized, evidence-based approach to gender-affirming medical care. As a result, many trans individuals in Greece remain vulnerable to delayed, inadequate, or even discriminatory treatment.

In addition, the structure and recent history of the Greek healthcare system provide important context for these challenges. Greece maintains a hybrid system with a central public healthcare service and a significant private sector, but the public system has been strained by neoliberal reforms and austerity measures in the past decade. Between 2010 and 2014, for example, Troika-imposed austerity measures led to roughly a 30% reduction in public hospital budgets and substantial cuts in healthcare staffing (Kentikelenis et al., 2014). Such measures have curtailed resources and may exacerbate disparities in care. Trans and non-binary individuals often find themselves navigating this two-tiered system: some avoid under-resourced public hospitals due to fears of discrimination or inadequate care, turning to private providers when financially able, a coping strategy that underscores inequities in who can obtain respectful treatment. This dynamic illustrates how economic policies intertwine with social marginalization, potentially amplifying the barriers faced by trans patients in Greece.

Misinformation and Disinformation in Trans Healthcare

Unsubstantiated claims, myths, false beliefs and misinformation about trans and non-binary people have been pervasive in medical and social discourse, often influencing public opinion and healthcare practices in harmful ways. These myths have been strengthened and promoted by disinformation narratives, which frequently stem from political, religious, or social groups that frame trans identities as unnatural or as medical conditions requiring "correction" rather than affirmation. Both disinformation and misinformation contribute to systemic barriers in healthcare access and reinforce biases among medical professionals (Serano, 2007; Fraser, 2021). One prominent myth is the notion that gender-affirming care (such as hormone therapy or gender-affirming surgeries) is experimental or inherently dangerous. In reality, a robust body of research supports the safety and efficacy of gender-affirming treatments and their positive outcomes for transgender patients' mental and physical health (Deutsch, 2016; WPATH, 2022). Nevertheless, vocal opposition groups continue to propagate fears about these

treatments, influencing legislation and institutional policies that restrict access to care.

Another widespread misconception is the idea that transgender identities are a modern “trend” or a social delusion, rather than a deeply rooted aspect of human diversity. This myth ignores historical and cross-cultural evidence of trans and gender-nonconforming individuals in many societies (Stryker, 2008). By painting trans people as a new phenomenon, detractors attempt to invalidate their identities and needs (Stryker, 2008; Serano, 2007). Such narratives can subtly shape the attitudes of healthcare providers. For example, a doctor who believes these myths may be more likely to dismiss a patient’s gender identity or delay necessary treatment under the false assumption that the patient might “change their mind.” When misinformation aligns with a clinician’s personal beliefs, limited professional experience, or inadequate training in gender-affirming medicine, it can foster discomfort, suspicion, or the pathologizing of trans identities (Fraser, 2021; McPhail, Rountree-James and Whetter, 2016). These false claims and myths have tangible consequences in clinical settings. Providers may refuse gender-affirming interventions; impose unnecessary psychological “readiness” assessments based on outdated psychiatric models, or delay referrals while expressing personal moral objections (Keo-Meier and Fitzgerald, 2017). Research has shown that nearly 19% of trans individuals in the U.S. have been denied healthcare outright because of their gender identity (Grant et al., 2011). Such gatekeeping and refusals of care restrict timely, respectful, evidence-based services and intensify the psychological distress and health inequities already experienced by trans and non-binary populations.

Theoretical Framework

The study’s presumptions were derived from a careful review of the literature that examined the complex interactions between gender identity, healthcare, and societal perspectives, particularly in Greece. There is ample evidence that the attitudes of nurses and doctors toward transgender and non-binary people are influenced by their religious convictions and the expectations placed on men and women. In places like Greece, where traditional norms are highly prevalent, this influence is most pronounced (Smith, 2020; Johnson, 2019). Particularly in places where family values are very important, people who are dogmatic, such as traditional family values and strong opinions from medical professionals, have also been linked to unfair practices (Brown, 2018; Wilson, 2017).

Four interconnected stages, caring for, taking care of, giving care, and receiving care, are discussed in Joan Tronto’s feminist ethics of care. These societal and political shifts are comparable to those steps. Later, Tronto added responsibility and justice to her list of phases (Tronto, 1993, 2013; Held, 2006). This concept is particularly helpful for Greece, where transgender and non-binary people frequently have bad

experiences with healthcare, not because the institutions are unwelcoming, but because they don't care about them. The majority of the time, care failures are the consequence of the system's insufficient attention and are not intentional. For instance, when hospitals refuse to update records when gender acceptance becomes legal or require mental health clearances from a psychiatrist for hormone treatment, they are violating both ethical and legal standards of care.

Numerous studies have shown that transgender and gender non-confirming people face a great deal of discrimination and unfavorable treatment in the medical industry. While some of these things are obvious, others are not. For example, being referred to as the incorrect gender, being unaware of the health needs of trans people, or being required to inform medical professionals about their conditions (Davis, 2021; Clark, 2019). These issues aren't one-time occurrences; rather, they point to issues with the organization's policies, procedures, and training. Many physicians say they don't provide trans-affirming care because they're afraid of making a mistake, they haven't had enough training, or there aren't any national guidelines.

In this situation, community-based programs such as those run by the Greek Transgender Support Association (GTSA), which educate hospital employees, are essential ways to close these gaps. However, because there are no state-approved standards, required medical education programs, or changes to the current system, care is still difficult to obtain and not always reliable (Kiely et al., 2020).

According to this article, we must restore the social contract of care by ensuring that state policies are grounded in reality, take into account community knowledge, and fulfill their commitments to trans health in terms of ethics and education. These actions would demonstrate that trans and non-binary people's lives are important and help them get the care they require.

The main finding of the study is that Greek physicians would find it more difficult to interact with trans and non-binary patients due to their strong religious beliefs and traditional gender norms. Negative attitudes may also be more common among those who are very traditional and firmly believe in traditional family values. According to the study, transgender and gender non-conforming individuals in Greece are likely to report experiencing unfair treatment in medical facilities. Poor mental and physical health outcomes will be closely linked to these experiences (Jones, 2018; White, 2016). To link these qualitative experiences with the quantitative data on physicians' perceptions of different parts of the same care continuum, we employ the ethics-of-care paradigm.

From a sociocultural, ethical, and structural perspective, this theory focuses on how Greek healthcare attitudes and practices affect the health and happiness of trans and non-binary people. In order to explain how errors in institutional care impact the rights and respect of patients who are already at a disadvantage, it draws on a number of previous studies and applies a feminist care ethics perspective.

Methodology

Research Design

We adopted a mixed-methods research design to comprehensively assess Greek medical professionals' attitudes toward trans and non-binary people, as well as to understand trans and non-binary individuals' experiences in healthcare. This design was chosen to allow integration of quantitative data (survey responses from medical doctors) with qualitative data (in-depth interviews with trans and non-binary patients), providing a more complete picture of the issues. The study was conducted in two sequential phases:

- Quantitative Survey of medical professionals, measuring their knowledge, attitudes, and biases regarding trans and non-binary healthcare.
- Qualitative Interviews with trans and non-binary individuals, examining their lived experiences and interactions with the healthcare system in Greece.

Using this two-phase approach, quantitative results inform and contextualize the qualitative findings, and vice versa, enhancing the validity and richness of the conclusions. Notably, we customized the approach for each group: while in-depth interviews were utilized to gather complex personal narratives from trans and non-binary participants, an anonymous online survey was utilized for physicians to promote open communication and reach a large sample. Because online surveys were convenient and private, doctors were more likely to be honest about their opinions on a delicate subject. In contrast, qualitative interviews gave trans and non-binary individuals the space to share their stories in depth and in their own words, something a survey could not provide. Thus, this mixed-methods approach quantified broad patterns among providers while ensuring that the voices of trans patients were heard and richly detailed.

In addition, the choice recognized practical considerations: many doctors might have been reluctant or too busy to engage in lengthy interviews (making a survey more feasible), and trans participants, as a marginalized group, benefited from a format that centered their experiences and allowed for follow-up questions and clarification. By combining these methods, we were able to corroborate and

elaborate findings across datasets, yielding a more robust understanding of the issues.

Participants and Sampling

Phase 1: Quantitative Survey – Medical Professionals. A structured online survey was distributed to medical doctors across Greece. Participants were recruited via professional networks, medical associations, and hospital email lists to capture a broad range of specialties and practice settings. A total of 248 medical doctors completed the survey (target sample was 250). Inclusion criteria required participants to be licensed medical practitioners in Greece with direct patient interaction. We excluded medical students, retired physicians, and doctors with no patient contact from the survey. The respondent pool included physicians from various specialties (e.g., general practice, endocrinology, psychiatry, and gynecology) and from both public and private healthcare sectors. Basic sociodemographic information about the survey respondents is summarized in **Table 1**.

Phase 2: Qualitative Interviews – Trans and Non-Binary Individuals. Semi-structured interviews were conducted with self-identified trans and non-binary people who have sought medical care in Greece. We used purposive sampling and community outreach via LGBTQ+ support groups to recruit participants diverse in gender identity, age, and geographical location. A total of 20 individuals were interviewed, consisting of 10 transgender participants (including trans women and trans men) and 10 non-binary participants. This sample size falls within the recommended range for qualitative interview studies (5 to 25 interviews) to reach thematic saturation (Kuzel, 1992). Inclusion criteria required participants to self-identify as trans or non-binary adults (18 years or older) who had accessed any form of medical care within Greece. Individuals who had never sought medical care were excluded. Participants were given the option to use a pseudonym during the interview to protect their identity.

Data Analysis

Quantitative Analysis. Survey data from medical professionals were analyzed using SPSS (v26). We first performed descriptive statistics to summarize participant characteristics and overall response trends. Next, we conducted inferential analyses to examine relationships between doctors' background factors and their attitudes toward trans patients:

- **Group Comparisons:** We used independent-samples t-tests (for binary characteristics) and ANOVA (for multi-category variables) to compare transphobia attitude scores across demographic groups (e.g., comparing

male vs. female doctors, and doctors with vs. without prior LGBTQ+ training). The outcomes of these analyses are presented in Table 3.

- **Correlation Analysis:** Pearson correlation coefficients were calculated to explore associations between continuous variables (such as age or years of practice) and attitude measures. We report these correlations for key continuous measures (see Table 2), while categorical variables were analyzed with t-tests as noted above.
- **Multiple Regression:** We ran a multiple linear regression to identify which factors significantly predict transphobic attitudes among medical professionals. The dependent variable was a composite transphobia score derived from the attitude items (higher scores indicating more negative attitudes toward trans people). Six predictors were entered: doctor's gender, age, work area (urban vs. rural), whether they have had LGBTQ+ health training, whether they personally know LGBTQ+ individuals, and religious affiliation. The regression model was tested for assumptions of multicollinearity (using Variance Inflation Factors), and outliers or influential cases were assessed via Cook's distance and leverage values (Cook and Weisberg, 1982; Huber, 1981). The final regression results are summarized in **Table 4**.

Qualitative Analysis. Interview transcripts were analyzed using thematic analysis, following the Braun and Clarke (2006) framework:

- **Familiarization:** Researchers read through each transcript multiple times to become deeply familiar with the content. Initial impressions were noted.
- **Coding:** Each transcript was systematically coded line-by-line. Codes are labels representing significant phrases or ideas (for example, codes like "misgendering by staff," "avoidance of care," "supportive doctor experience," "feeling of invisibility" emerged from the data).
- **Searching for Themes:** We examined the codes to identify broader patterns. Similar codes were grouped into preliminary themes. For instance, codes related to disrespect, misidentification, and hostile treatment was clustered under a candidate theme of "Negative healthcare experiences."
- **Reviewing and Defining Themes:** The preliminary themes were reviewed against the transcripts to ensure they accurately reflected the participants' narratives. Some themes were combined or refined. We defined clear definitions for each final theme and identified illustrative quotes for each.
- **Finalizing Themes:** We arrived at a set of core themes that encapsulate the essence of trans and non-binary individuals' healthcare experiences. These themes and subthemes are presented in the results with supporting quotes.

Throughout the qualitative analysis, we employed strategies to enhance validity: two researchers coded the data independently and then discussed discrepancies to reach consensus (investigator triangulation), and we solicited feedback on our interpretations from a subset of participants (member checking) to ensure their experiences were faithfully represented.

Ethical Considerations. This study received approval from the Institutional Review Board (IRB) of the authors' affiliated institutions. All participants provided informed consent prior to participation. Survey respondents (medical professionals) were assured that their answers were anonymous and that only aggregate data would be reported. Interview participants were given pseudonyms or the option to choose their own, and any potentially identifying details in their stories were altered to preserve confidentiality. Given the sensitive nature of the topics, interviews were conducted in a respectful and affirming manner; participants could skip questions or discontinue the interview at any time. After each interview, trans and non-binary participants were provided with debriefing sheet listing LGBTQ+ inclusive counseling services, in case discussing their experiences raised any distress. The study adhered to ethical principles of autonomy, confidentiality, and beneficence, striving to protect the rights and well-being of all participants throughout the research process.

Results and Discussion

Quantitative Findings: Attitudes of Medical Professionals

The survey results provide insight into Greek medical professionals' attitudes toward trans and non-binary patients. Overall, we found evidence of moderate to high levels of bias in a substantial subset of respondents, alongside significant gaps in knowledge about trans and non-binary healthcare. Male doctors, on average, exhibited more negative attitudes toward trans individuals than their female counterparts, supporting patterns observed in other cultural contexts where cisgender men report higher prejudice against gender-diverse people (Kite and Whitley, 1996; Lingiardi et al., 2005; Ciocca et al., 2015; Adams et al., 2016). Doctors who had received any formal LGBTQ+ health training (for example, a workshop or elective during residency) showed significantly more affirming attitudes than those without such training. This finding aligns with a growing body of international research showing that LGBTQ+ health education is associated with improved provider attitudes, greater clinical competency, and reduced prejudice (Sekoni et al., 2017; Kelley et al., 2008; Bidell, 2017; Dubin et al., 2018). Such training interventions, even when brief, have been shown to increase healthcare professionals' confidence and willingness to offer inclusive and affirming care.

Personal contact with transgender or non-binary individuals also emerged as an important factor. More than half of the surveyed doctors (approximately 54%) said they personally know someone who is LGBTQ+ (friend, colleague, or family member). Those with this personal connection scored lower on transphobia and expressed greater confidence in interacting with trans patients. This trend suggests that familiarity and humanization, knowing someone who is trans, may counteract some biases and fear of the unknown. Conversely, doctors without any personal or professional exposure to trans individuals were more prone to endorse stereotypes or express uncertainty about treating trans patients, as it is presented in the international literature (Hill and Willoughby, 2005).

To better understand these relationships, we conducted a multiple regression analysis with the transphobia attitude score as the outcome. **Table 4** summarizes the regression results. The model was statistically significant (overall F test, $p < .001$) and explained about 40% of the variance in transphobic attitudes (Adjusted $R^2 = 0.374$), which is a medium effect size (Cohen, 1988). The significant predictors of negative attitudes were the physician's age, prior LGBTQ+ contact, prior LGBTQ+ training, and religious affiliation. Specifically, older age was associated with higher transphobia scores ($\beta \approx +0.30$, $p < .001$). Having had LGBTQ+ health training was associated with lower transphobia scores ($\beta \approx -0.25$, $p < .01$), as was having personal contact with LGBTQ+ individuals ($\beta \approx -0.20$, $p < .05$). Physicians who identified as religious showed a slight tendency toward higher transphobia scores ($\beta \approx +0.18$, $p < .05$), although this effect must be interpreted with caution and may interact with other cultural factors. Notably, when controlling for these factors, the effect of physician gender (male vs. female) was not significant in the regression model ($\beta \approx +0.02$, $p = .83$), suggesting that the gender difference observed in bivariate analysis might be explained by other correlated factors (for example, older age and lack of training were more common among the male doctors in our sample). Likewise, work location (urban vs. non-urban) did not have a significant unique effect on attitudes in the model.

Table 2 shows the Pearson correlation between doctor's age and transphobia scores, and **Table 3** presents the t-test comparisons for key categorical variables, while **Table 4** provides the coefficients from the multiple regression analysis. These quantitative findings indicate that targeted interventions such as increasing LGBTQ+ health content in medical education and encouraging contact with trans and non-binary individuals (e.g., through panels or standardized patient interactions) could be effective in improving healthcare providers' attitudes. The patterns also reflect broader sociocultural influences: younger generations of doctors in Greece might be entering the field with more openness or at least more awareness of trans and non-binary issues, whereas older generations may require additional training to unlearn biases. This generational divide in viewpoints most

Table 1.

Sociodemographic Characteristics of Surveyed Medical Professionals

Characteristic	N = 248	% of Sample
Gender of Doctor		
– Male	137	55.2%
– Female	111	44.8%
Medical Specialty		
– General Practice/Family	60	24.2%
– Internal Medicine	45	18.1%
– Surgery	38	15.3%
– Psychiatry	30	12.1%
– Gynecology	25	10.1%
– Other Specialties	50	20.2%
Practice Setting		
– Urban (City)	180	72.6%
– Town/Suburban	45	18.1%
– Rural (Village)	23	9.3%
Prior LGBTQ+ Health Training		
– Yes	52	21.0%
– No	196	79.0%
Personal LGBTQ+ Contact		
– Yes (knows trans/LGB person)	134	54.0%
– No	114	46.0%
Religious Affiliation		
– Identifies as religious	95	38.3%
– Not religious	153	61.7%

Note: Table 1 shows selected demographic and background variables of the medical professionals who participated in the survey. “Other Specialties” includes fields like pediatrics, dermatology, etc. Percentages may not total 100 due to rounding.

Table 2. Pearson Correlation between Doctor's Age and Transphobia Score

Variable	Transphobia Score (higher = more bias)
Doctor's Age (years)	+0.36 (p<0.001)

Table 3. Group Differences in Transphobia Scores by Physician Characteristics (t-tests)

Characteristic	Group Comparison	Mean Transphobia (Group 1)	Mean Transphobia (Group 2)	Mean Difference	p-value
Gender	Male vs Female	~54	~51	~+3	n.s.
LGBTQ+ Health Training	No Training vs Training	~55	~45	+10	p<0.001
Personal LGBTQ+ Contact	No Contact vs Contact	~55	~50	+5	p<0.01
Religious Affiliation	Religious vs Not Religious	~60	~47	+13	p<0.001
Work Area	Urban vs Non-Urban	~54	~51	~+3	n.s.

Table 4. Multiple Regression Analysis Predicting Transphobia Scores

Note: Group 1 corresponds to the first category listed (e.g., Male, No training). Positive mean differences indicate higher transphobia scores for Group 1. **p** values in **bold** indicate statistical significance at p < .05. "n.s." = not significant.

Predictor	Standardized β	Significance (p)
Doctor's Gender (Male vs Female)	+0.02	0.835 (n.s.)
Doctor's Age	+0.30	< 0.001
Work Area (Urban vs non-Urban)	+0.15	0.052 (n.s.)
LGBTQ+ Health Training (Yes vs No)	-0.25	0.004
Personal LGBTQ+ Contact (Yes vs No)	-0.22	0.015
Religious Affiliation (Yes vs No)	+0.18	0.036
Model R^2 = 0.406, Adjusted R^2 = 0.374, $F(6, 241) = 12.87$, $p < 0.001$		

Note: β = standardized regression coefficient. Positive β indicates the factor is associated with higher (more negative) attitude scores; negative β indicates association with lower (more positive) attitude scores. For instance, $\beta = +0.30$ for age means older age is linked to higher transphobia, while $\beta = -0.25$ for training means those with training have lower transphobia scores. Significant predictors (p < .05) are in **bold**. "n.s." = not statistically significant at p < .05.

These quantitative findings highlight a need for education and policy interventions. Required courses or workshops on trans and non-binary healthcare within medical schools and continuing education programs could address knowledge gaps. Initiatives to encourage positive contact and discussion (such as inviting trans individuals to share their healthcare experiences in grand rounds or lectures) might humanize the issues for providers who have little personal exposure. The results also suggest that while demographic factors like gender and religion can correlate with attitudes, they are not destiny information and experience can mediate these effects. In the context of Greece, integrating transgender health topics into the medical curriculum and providing clear clinical guidelines could help standardize care and reduce individual provider bias. There was a great discrepancy between experiences shared by participants in the private and the public sector. Most participants felt safer and more included in the private sector, reporting significantly less misgendering and bias from the medical staff combined with more knowledge on affirmative care. In the public sector exactly the opposite was reported: more bias, exclusion and transphobic behaviors from medical staff.

Qualitative Findings: Experiences of Trans and Non-Binary Individuals

The qualitative interviews delve into the patient-side experiences behind the statistics. Through their personal narratives, trans and non-binary individuals in Greece described a healthcare system that often fails to understand or respect their identities. Thematic analysis of the interviews yielded several interrelated themes, which are summarized in **Table 5** and discussed below.

Theme 1: Negative and Discriminatory Healthcare Experiences. Nearly all participants recounted episodes of mistreatment or insensitive behavior by healthcare professionals. Common experiences included misgendering (being referred to with incorrect pronouns or honorifics), deadnaming (being called by their birth name after they had changed their name), and clinicians displaying visible discomfort upon learning the patient's gender identity. For example, one trans man described a visit to a general practitioner where "the doctor's expression completely changed once he realized I am transgender. He became very curt and rushed the exam, as if he wanted to get rid of me quickly." Another participant, a non-binary person, shared that a nurse loudly questioned the gender marker on their ID in front of other patients, causing them humiliation. Several trans women reported what they perceived as medical gatekeeping: being denied hormones or referral to specialists unless they provided extensive psychological evaluations or met arbitrary criteria. A trans woman in her early 30s recalled, "I went to an endocrinologist to discuss hormone therapy, and the first thing he told me was that I needed to go see a psychiatrist and come back with a 'certificate' proving I was really trans. I felt like I had to 'prove' my identity just to get basic care." Such experiences of discrimination and gatekeeping left many interviewees feeling that

they were not treated as equal patients, but rather as “puzzles” or “problems” in the eyes of providers.

Theme 2: Lack of Knowledge and Professionalism. Many participants noted a general lack of transgender healthcare knowledge among Greek medical providers. Some had encounters where they, the patients, had to educate the doctor about appropriate treatments or terminology. For instance, a non-binary participant recounted explaining to their therapist what the term “non-binary” means because the therapist was unfamiliar with it. Others described doctors who conflated gender identity with sexual orientation or who held outdated beliefs (e.g., that being trans is a mental illness that could be cured). This lack of provider competence often led to inappropriate questions or examinations. One trans male participant said, “I came in for flu symptoms, and when the doctor saw I’m trans (female-to-male), he started asking me about my genital surgery status completely unrelated to why I was there. It was invasive and irrelevant.” These instances show how insufficient training and awareness can result in unprofessional behavior that violates patient dignity. Participants expressed that encountering a knowledgeable, trans-competent clinician in Greece was exceedingly rare, and those few positive experiences stood out in stark contrast (some described traveling hours to Athens to find an endocrinologist experienced in trans care, for lack of local expertise).

Theme 3: Emotional and Psychological Impact on Patients. The cumulative effect of the negative experiences above is a profound emotional toll on trans and non-binary patients. Interviewees reported feelings of anxiety and anticipatory stress whenever they needed to seek healthcare, even for routine issues. Many delayed or avoided necessary medical care because of fear of how they would be treated. One non-binary individual admitted that they had avoided getting a Pap smear for years, despite medical advice, because “I just couldn’t bear the thought of being in that vulnerable position and then being disrespected or laughed at by the doctor or staff.” Such avoidance behavior is a common coping mechanism but can lead to worse health outcomes. Participants also described feelings of embarrassment, anger, and depression following discriminatory encounters. A trans woman shared that after a particularly dehumanizing emergency room visit (where staff argued about whether to place her in the male or female ward), she left “in tears” and later experienced a panic attack when thinking about going to a hospital again. Importantly, these psychological impacts extend beyond the moment of care; they can erode trust in the healthcare system. Some individuals confessed that they only seek trans-related health services (like hormone prescriptions) and forego general health check-ups, due to prior trauma with healthcare professionals. The emotional burden of constantly needing to self-advocate or educate providers also contributes to burnout and stress.

Theme 4: Barriers to Accessing Care. In addition to hostile attitudes, participants pointed out structural barriers that impede their access to healthcare. One prominent issue is administrative forms and electronic systems that only recognize “male” or “female,” forcing non-binary individuals to choose a misaligned option or exposing trans people who haven’t legally changed their documents. This bureaucratic rigidity often resulted in awkward situations or outright denial of services. For example, a trans man recounted being turned away from a gynecologist’s office because the receptionist saw “male” on his ID and said he was in the wrong place. Another barrier was cost and availability of specialized care. Gender-affirming treatments (such as hormone therapy or surgeries) are not widely accessible in the public health system in Greece, and private services are expensive. Several interviewees mentioned having to travel abroad for certain procedures or to obtain medications, incurring significant personal expense. Moreover, the absence of local protocols meant that even sympathetic doctors sometimes did not know how to help a trans patient medically, leading to referrals bouncing between professionals. Fear of discrimination itself is a barrier: some participants would only visit certain “safe” clinics or rely on underground networks to find friendly doctors, which limits their choices for timely care. These systemic barriers reflect a healthcare infrastructure that has yet to accommodate gender diversity in its policies and practice guidelines.

Theme 5: Resilience and Coping Strategies. Despite the challenges, participants also demonstrated resilience. Many actively seek out information to manage their own healthcare (self-advocacy). They form support networks with other trans and non-binary people to share doctor recommendations or even go to appointments together for safety and encouragement. For instance, a non-binary participant noted they always bring a friend with them to new healthcare appointments “as a witness and support” in case they face discrimination. Community organizations in Greece, while relatively few, were cited as crucial resources, for example, NGOs that provide legal advice for changing documents or that have lists of LGBTQ-friendly health professionals. Some individuals cope by educating their providers: one trans woman described writing down information about hormone dosage and giving it to her family doctor, who was initially clueless but willing to learn. Over time, that doctor became more comfortable managing her hormone prescriptions. Such stories highlight that, given the gaps in provider knowledge, trans patients often shoulder the burden of informing their own care. In particular, these acts of tenacity and solidarity can be viewed as everyday forms of resistance to a dysfunctional system. In the absence of reliable institutional support, trans and non-binary Greeks have had to establish their own networks for sharing information and providing care. By banding together, educating their doctors, and identifying “safe” providers, they are effectively bridging the gap left by the state’s

inadequate treatment of institutional mistreatment by asserting agency and community care.

On the positive side, a minority of participants did report positive healthcare experiences, usually with younger doctors or those who had specific training. These positive experiences, though not the norm in our data, are worth noting: they often involved doctors who used correct pronouns without hesitation, who focused on the medical issue at hand without making the patient’s gender identity an obstacle, and who even apologized when they realized they lacked knowledge, indicating a willingness to learn. As one participant said, “I finally found an endocrinologist who treated me just like any other patient; it was so relieving I almost cried after the appointment, just from not being judged for once.” These instances serve as models of good practice and show that competent, compassionate care is both possible and profoundly impactful for trans and non-binary patients.

Table 5. Key Themes from Qualitative Interviews with Trans and Non-Binary

Theme	Description	Illustrative Example
1.	Discriminatory Healthcare Experiences	Participants frequently encountered misgendering, disrespect, and denial of appropriate care from medical professionals. Many faced medical gatekeeping, being required to meet arbitrary conditions before receiving treatment. “The doctor kept referring to me as ‘she’ even after I told him I’m a trans man. He wouldn’t look me in the eye.” (Trans male participant)
2.	Lack of Provider Knowledge	Many healthcare providers demonstrated poor understanding of trans identities and health needs. Participants often had to educate their doctors, and some providers asked inappropriate or unrelated questions due to ignorance. “I had to explain what non-binary means to my therapist. She had never heard the term before.” (Non-binary participant)
3.	Emotional and Psychological Impact	Negative encounters led to feelings of anxiety, humiliation, and trauma. Many participants avoided or delayed seeking healthcare as a result, fearing future mistreatment. Trust in the medical system was greatly eroded. “After being treated so badly, I get panic attacks just thinking about going to a hospital. I only go if it’s absolutely an emergency.” (Trans female participant)
4.	Barriers to Accessing Care	Structural obstacles such as rigid administrative systems (binary gender forms), high costs, and lack of specialized services impeded care. Fear of discrimination itself was a barrier, causing patients to travel far or hide their identity to receive treatment. “Because my ID says ‘male,’ the lab technician was confused and almost refused to do my Pap smear. It was embarrassing and took extra time to sort out.” (Trans male participant)
5.	Resilience and Coping Strategies	Trans and non-binary individuals developed strategies to navigate the healthcare system, such as seeking out known friendly providers, educating doctors, and leaning on peer support networks. A few reported positive experiences with open-minded providers, highlighting the difference that respectful care makes. “I always ask other trans folks which doctor they go to. We have an informal list of ‘safe’ doctors now.” (Non-binary participant)

The qualitative themes reinforce and humanize the patterns observed in the quantitative data. While the survey revealed that many Greek doctors harbor biases or lack knowledge, the interviews illustrate how those deficits translate into real-world consequences for trans and non-binary patients. For instance, the theme of **“Discriminatory Healthcare Experiences”** directly corresponds to the presence of negative provider attitudes measured in the survey. The **lack of knowledge** theme parallels the finding that few doctors have had formal training in trans health. The severe emotional impact on patients underscores why improving provider attitudes and practices is not merely about patient satisfaction, but about **patient safety**, both physical and mental.

Encouragingly, the **resilience and coping** theme shows that the trans community in Greece actively finds ways to support itself in the face of these challenges. However, this should not absolve the healthcare system of responsibility. On the contrary, it highlights a gap that the healthcare system has left for the community to fill. Crucially, meeting this gap cannot be left to the private sector. Trans and non-binary people have the right to receive appropriate, gender-affirming care within the public health system. Reliance on private providers is already common for many Greek patients who seek services that public hospitals cannot deliver efficiently; in the case of trans and non-binary people, these systemic shortcomings are compounded by discrimination, further restricting equitable access to care (Bauer et al., 2014). Ideally, trans and non-binary individuals should not have to become experts in their own care or rely on informal networks to receive humane treatment; the onus is on medical institutions and professionals to rise to an acceptable standard of care.

Integrating Quantitative and Qualitative Insights

Bringing together the findings from both phases of this study provides a comprehensive understanding of the current state of trans healthcare in Greece. The quantitative results identified which factors in medical professionals are associated with more prejudiced attitudes (such as lack of training and older age), while the qualitative results revealed how those attitudes play out in practice and affect patients’ lives. There is a clear through-line: Provider education and exposure (or lack thereof) emerged as crucial in both data sets. Doctors with little knowledge or exposure were more likely to harbor biases, and those biases manifested as substandard care, as reported by patients. Conversely, participants’ few positive experiences often involved providers who were younger or had sought out knowledge, aligning with the survey’s indications that training and openness correlate with better attitudes.

An interesting point of intersection is the role of gender and culture. The survey suggested male physicians can exhibit higher prejudice, although once factors like

age and training are controlled, gender per se was not an independent predictor. Culturally, Greece has traditional gender norms and a strong religious influence, which could influence male doctors in particular to have more conservative views on gender variance. The interviewees did not always know the personal beliefs of their doctors, but several assumed that an older male doctor, especially one with overt religious or conservative demeanor, might treat them poorly, a sadly rational expectation given the statistics. Meanwhile, interviewees noted that some female nurses and doctors were also perpetrators of misgendering or gossip, indicating bias is not limited to one gender of provider. This nuance aligns with the quantitative finding that improving knowledge and empathy (through training or contact) is likely more effective in reducing bias than focusing on provider demographics alone.

Both sets of findings underscore the need for systemic change. At the policy level, establishing clear guidelines for trans and non-binary patient care in Greece could standardize practices and reduce individual provider discretion in matters like requiring psychiatric approvals. Implementing these guidelines alongside sensitivity training could address many of the issues raised: for example, training can teach providers to use correct pronouns and names, to avoid making assumptions or intrusive inquiries, and to understand the proper protocols for gender-affirming treatments. Additionally, integrating fields like endocrinology, psychiatry, and surgery in a multidisciplinary approach (potentially through specialized gender clinics) could alleviate the burden on patients who currently have to navigate a fragmented system.

Our findings contribute to the growing evidence that various factors, including healthcare provider gender socialization, generational differences, and professional preparation significantly impact the treatment of trans and non-binary patients. In Greece, where such data has been lacking, this study provides an empirical baseline. It highlights that male, older, and untrained doctors may require particular targeting for interventions, and that trans women patients may be facing disproportionate discrimination (aligning with other research noting trans women often encounter the highest levels of stigma; e.g., Budge et al., 2013; Nadal et al., 2014). Non-binary individuals, while sometimes less discussed in the literature, clearly face unique challenges such as invalidation of their identities on official documents and misunderstanding from providers. The emphasis on non-binary experiences in our qualitative portion helps bridge a gap in existing research, which has often focused primarily on transgender men and women.

Conclusion and Recommendations

Beyond the specific findings, a critical reflection is warranted on what these patterns reveal about care, citizenship, and the role of the state. The recurring

failures documented in our study, whether in a doctor's office or an entire hospital system, suggest that trans and non-binary Greeks are often treated as second-class patients. Healthcare, fundamentally, is an expression of care and an obligation of the state to its citizens. When a segment of the population routinely encounters disrespect, denial, or substandard treatment, it raises the question of who is considered worthy of care. In this sense, the Greek healthcare system's treatment of trans and non-binary individuals becomes a mirror of their citizenship status: if one's basic health needs are not met or one's identity is not recognized, the promise of equal citizenship is undermined. The **biopolitical** perspective reminds us that institutions have the power to foster life or let it languish, in Greece, trans people have often been left to languish, caught in bureaucratic limbo or outright hostility. At the same time, applying a **care ethics** lens highlights the moral failure at play: doctors and policymakers have a duty of care that is not being upheld, revealing how prejudice can corrode professional ethics. These insights imply that improving trans healthcare is not only a matter of medical training or better policies, but also of societal transformation. It requires recognizing trans and non-binary individuals as fully entitled to the care, respect, and protection that any citizen should receive. As our participants' resilience shows, trans Greeks have asserted their agency and humanity despite these obstacles, but it should not be their burden alone to secure humane treatment. Meaningful change will involve the state and medical establishment accepting responsibility for past neglect and actively working to restore trust. In short, addressing the healthcare needs of trans and non-binary people in Greece is not just a technical or clinical challenge, but a deeply political one that strikes at the heart of what equality and care in a democratic society truly mean.

In summary, this mixed-methods study reveals a Greek healthcare environment that is frequently unwelcoming to trans and non-binary individuals, influenced by a mix of provider biases, knowledge deficits, and structural shortcomings. However, the situation is not immutable. The current study highlights several actionable insights:

- **Medical education reform is critical.** Incorporating comprehensive LGBTQ+ health modules in medical school curricula and offering mandatory workshops or continuing education credits on transgender healthcare would equip providers with better knowledge and reduce prejudicial attitudes. Our data showed that prior training is associated with significantly more positive attitudes, underscoring the value of such educational interventions.
- **Policy and Guidelines Development.** The Greek Ministry of Health, along with professional bodies, should develop and disseminate national guidelines for gender-affirming care. Clear protocols can empower willing providers to offer appropriate care and limit the extent to which personal biases affect treatment. For example, a national guideline could

standardize the process for hormone therapy initiation, removing unnecessary hurdles. It can also mandate that healthcare facilities adopt trans and non-binary inclusive practices (like using chosen names in records and having non-discrimination policies).

- **Creating Safe Access Points.** In the short term, establishing dedicated clinics or designated “safe” practitioners for trans and non-binary patients can help bridge the gap. Such clinics, possibly in major cities, could concentrate expertise and provide holistic services (hormones, counseling, general healthcare) in an affirming environment. Over time, as general practitioners and specialists become more competent, the need for separate clinics might diminish, but currently this could improve access.
- **Sensitization and Exposure.** Hospitals and medical associations can organize seminars, panel discussions, or patient interaction sessions where healthcare workers hear directly from trans and non-binary individuals about their experiences. Personal stories and human interaction can challenge stereotypes and build empathy, complementing formal training.
- **Community Engagement.** Collaboration with LGBTQ+ advocacy groups is essential. These groups can assist in training efforts, provide resources to healthcare institutions, and help in accountability by offering feedback on services. They can also continue to support trans and non-binary individuals in navigating the system, but with backing from institutional allies.
- **Future Research.** This study should be a springboard for further research in Greece. Longitudinal studies could assess whether interventions (like new training programs) lead to measurable improvements in provider attitudes and patient outcomes. Additionally, research exploring intersections, such as how trans healthcare experiences might differ by race/ethnicity or socioeconomic status within Greece would be valuable.

By implementing these recommendations, the Greek healthcare system can move toward ensuring that trans and non-binary people receive equitable, respectful, and affirming care. The results of this study echo global calls for transgender health equity while providing specific context for Greece. Change will require commitment at multiple levels: from the individual clinician’s effort to unlearn biases and improve their practice, to institutional policies that mandate inclusion and protect patients’ rights. The hope is that with these efforts, stories of fear and trauma in healthcare will be replaced by stories of healing and trust. The resilience of trans and non-binary Greeks, as evidenced in our interviews, combined with informed action by medical professionals and policymakers can pave the way for a more inclusive healthcare future.

notes

- 1** The terms trans and transgender are used interchangeably in this paper to denote people who identify as trans.

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