Trust in physicians among young sexual minority men

Yifan Lai¹, Madeline Cohodes², Marybec Griffin³,⁴, Tejossy John⁵, Benjamin Grin⁶, Perry N. Halkitis³,⁴,⁷, Jessica Jaiswal⁴,⁵,⁷,.*

¹Yale School of Public Health, Yale University, New Haven, CT 06520, USA
²School of Medicine, Emory University, Atlanta, GA 30322, USA
³Department of Health Behavior, Society & Policy, Rutgers School of Public Health, Rutgers University, New Brunswick, NJ 08901, USA
⁴Center for Health, Identity, Behavior & Prevention Studies, Rutgers University, New Brunswick, NJ 08901, USA
⁵Department of Family and Community Medicine, Heersink School of Medicine, University of Alabama at Birmingham, Birmingham, AL 35233, USA
⁶Department of Primary Care College of Osteopathic Medicine, Kansas City University, Kansas City, MO 64106, USA
⁷Department of Biostatistics & Social and Behavioral Health Sciences, Rutgers School of Public Health, Rutgers University, New Brunswick, NJ 08901, USA
⁸Center for Interdisciplinary Research on AIDS, Yale University, New Haven, CT 06520, USA

*Correspondence
jessica.jaiswal@uabmc.edu
(Jessica Jaiswal)

Abstract

Trust in physicians and the medical establishment more broadly is critical for access to and provision of relevant healthcare services. This is especially true for sexual minority men (SMM) as their healthcare is negatively impacted due to stigma and discrimination which in turn affects disclosure of sexual behavior and sexual orientation. This study sought to understand trust in physicians (TIP) as it relates to anal sex position, difficulty in paying for healthcare, insurance status, and pre-exposure prophylaxis (PrEP) use. This study employs data from a cross-sectional survey conducted between February 2018 and February 2019. The final analytic sample is 179 sexual minority men who reported an human immunodeficiency virus (HIV) negative serostatus and identified as a sexual minority person (i.e., non-heterosexual). The present use of the Trust in Physicians Scale is further dichotomized for analytical purposes. The results show that slightly over half of the participants (52%, n = 93) reported trusting their physicians. Higher trust in physician scores were associated with preference of anal sex position (insertive or receptive as opposed to versatile/no preference), less difficulty in paying for health care services, people who were uninsured, and those who were currently using PrEP. In conclusion, TIP plays a critical role in disclosure of sexual orientation and sexual behaviors that allow for the delivery of necessary and appropriate healthcare services. Findings from this study can be used to develop best practices for taking patient histories that foster trust and disclosure of sensitive health information.

Keywords

Sexual minority men; Trust in physicians; PrEP; Healthcare

1. Introduction

Trust in physicians is an integral part of health care provision and the patient-physician relationship. Interpersonal trust is defined as a person’s belief that physicians’ words and actions are credible and reliable [1]. The patient-physician relationship is inherently hierarchical due to the patient’s dependency on the physician’s knowledge and use of treatments [2]. A patient who trusts their physicians believes that the physician is acting in the best interest of the patient and will provide supportive care [1]. Trust in physicians is linked to the degree to which patients seek routine medical care [3], adhere to prescribed medication [4], and maintain long term relationships with providers [3]. It can also impact a patient’s comfort levels with disclosing health information [5], and is linked to self-reported ability to manage chronic diseases, and health improvement [6]. Additionally, patients with higher trust in their physicians are more likely to report engaging in health behaviors such as exercise and safer sexual practices [7]. Insurance also affects trust; trusting one’s healthcare provider to put the patient’s needs above all else and to refer to the proper specialists has been found to be higher in those with indemnity and Preferred Provider Organization plans (PPO) (i.e., a type of medical plan that offers coverage to the enrollee via a network of select providers) as opposed to those in closed and open Health Management Organizations (HMO) (i.e., a type of medical plan that limits coverage to services provided only by providers who work for or contract with the insurance plan) combined [8].

Health inequities are most pronounced among minoritized communities. For example, in the U.S., structural racism-driven inequities in medical care continue to worsen [9]. Differences in trust in physicians is associated with racial disparities in health and access to health care, specifically among Black people. In one study, white respondents were 37% more likely to trust their physicians than Black respondents [10]. Historical precedents such as the Tuskegee experiments, ongoing systematic discrimination, and socioeconomic inequalities are some of the factors that influence trust in physicians across marginalized individuals in the U.S. [10].

Sexual minority men (SMM), another minoritized population in the U.S., also experience disproportionate healthcare-related inequalities. Young SMM experience myriad intersecting forms of oppression, highlighting the intersectional nature of their daily lived experiences [11]. Unpartnered SMM are less likely to have private health insurance than hetero-
sexual or same-sex couples [12]. Specifically, Black sexual minority men are also less likely to have insurance than Black and white heterosexual men [13]. Sexual minority people also experience financial barriers to medical care, and studies have shown that gay men of color have significantly elevated unemployment rates relative to white men (Odds Ratio 1.7). For instance, compared to heterosexual counterparts, in one study showed that 17% of gay men delayed or did not receive care because of cost in the preceding year (as opposed to 11.7% of heterosexual men) [14]. In terms of insurance status, research indicates that uninsured adults are less likely to get preventive and physician care, resulting in fundamental differences in health outcomes [15]. All of the factors can lead to SMM having higher financial barriers to care along with a lack of resources and providers specific for their health needs, furthering the lack of access to care in this population.

Additionally, due to provider-based discrimination and lack of resources for sexual minority health, some choose not to seek or maintain care. Trust in physicians among SMM is an emerging area of research [16] as this population often faces discrimination in healthcare settings [17], heterosexist assumptions made by providers [18], and a lack of provider knowledge about the specific healthcare needs of SMM [19]. Experiences of stigma, micro-aggressions, and lack of physician knowledge of SMM’s healthcare needs have also been linked to decreased trust in physicians. Prior studies have shown significant correlations between healthcare provider trust and PrEP uptake among different populations [20–22]. Among them, one study of young Black SMM showed that perceived experiences of discrimination and homophobia in healthcare provider interactions appeared to negatively influence PrEP uptake [23]. Another study of a cohort of Latinx SMM found greater lack of trust was associated with decreased outcomes in all stages of PrEP engagement as an HIV prevention strategy [21]. One study discovered that not being on PrEP was one characteristic associated with lower patient-provider trust among SMM, but using only a five-question scale giving limited analytical power [24]. These studies suggest that trust in physicians, or more often, lack of trust, is a salient concern for this often marginalized population, especially in regard to HIV prevention.

Although most literature on physician trust and SMM focus on HIV prevention, less is known about trust in physicians generally. Specifically, there is a lack of understanding around the potential relationship between preferred anal sex position and trust in physicians. Stigma associated with preferred anal sex position is well documented in the literature [25] and is often associated with non-disclosure of sexual activity due to fears of homophobic micro-aggressions by providers [25] and lack of physician knowledge of the healthcare needs of gay men [22]. Although preferences for anal sex positions are often used by SMM in establishing their identities, limited studies have analyzed current HIV prevention strategies and outcomes that vary based on different sexual roles, let alone investigations on the correlations between preferred anal sex positions and trust in physicians endorsements, which can be also be predictive of HIV care outcomes. Therefore, examining how trust in physicians is associated with certain socio-demographic and structural factors pertaining to healthcare access can allow providers to ascertain best practices for working with SMM and responding to their needs. This study sought to understand the relationship between trust in physicians in sexual minority and variables such as anal sex position, difficulty in paying for healthcare, insurance status, and pre-exposure prophylaxis (PrEP) use.

2. Methods

2.1 Study design and analytic sample

This analysis relies on data from the mixed-methods Health-Related Beliefs Study, a supplement to the P18 Cohort Study. All participants for the Health-Related Beliefs Study were recruited from participants enrolled in The P18 Cohort study, the parent study. The P18 Cohort Study is a prospective longitudinal cohort study that explores HIV, substance use, and mental health within a syndemic framework among a racially, ethnically, and socioeconomically diverse sample of young adult men and gender women who have sex with men who are living in New York City (NYC). The details of the P18 Cohort Study have been published elsewhere [25]. Briefly, participants for the P18 Cohort Study were recruited via lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and other sexual minority identity terms (LGBTQ+) community events, queer spaces, street-intercept in NYC neighborhoods, and dating/hookup sites (e.g., Grindr, Hornet, Scruff and Craigslist). Participants were eligible for the P18 study if they were between 18 and 19 at the time of the outreach event, assigned male at birth, had a HIV negative serostatus at the time of recruitment, reported having sex with another person assigned male at birth within the previous six months, and provided written informed consent.

The Health-Related Beliefs Study is a cross-sectional study that employs a convenience sampling methodology from the P18 Cohort Study. All participants enrolled in the Health-Related Beliefs Study were invited to enroll in this supplemental study during their biannual visit, by phone or by email. All recruitment efforts took place from February 2018 to February 2019. To be eligible for this study, participants needed to have a HIV-negative serostatus as confirmed by HIV antibody testing during their P18 study visit and provide written informed consent. All eligible participants completed a brief computer-based survey covering topics such as experiences with healthcare providers, thoughts about the healthcare system, and sexual health related beliefs. The analytic sample comprised cisgender men to avoid conflating the experiences of SMM and transgender women. Thus, participants self-reporting as cisgender male and non-heterosexual were included in the analysis. This resulted in 179 out of 202 eligible and verified survey responses. It should be noted that the key sociodemographic factors (e.g., race, gender, sexual orientation) of the participants in the supplemental study (n = 202) did not differ significantly from the Phase 2 P18 Cohort Study (n = 665).

2.2 Measures

2.2.1 Sociodemographic variables

Sociodemographic variables analyzed in this study include age, race, ethnicity, sexual orientation, and preferred anal sex
2.2.3 Trust in physicians

Dichotomous (yes/no) responses to their current and historical use of PrEP were collected. Such negatively worded items include Q1, Q5, Q7 and Q11. Subsequently, a continuous, cumulative score, ranging from 11 to 55, was created by summing up each participant’s responses to the 11 items. A higher cumulative score indicates a greater level of trust toward healthcare providers.

2.3 Analytic plan

The demographic and behavioral characteristics of this sub-sample will be described via univariate analyses including means, medians, confidence intervals (CI), and standard deviations (SD) for continuous variables and counts and proportions for categorical variables. The primary outcome is self-reported TIP endorsement. The outcome will be first quantified according to each question, respectively as described above. The individual score for each question will be added up to form a cumulative score. The internal consistency reliability of the adapted TIP scale questionnaire will be evaluated using inter-item correlation coefficients. Frequencies of different responses using a Likert scale to each TIP question will be reported.

Potential facilitators or barriers of TIP endorsement among SMM will be dichotomized considering the relatively small sample size of this supplemental study. Bivariate analyses will be conducted to determine specific variables that were significantly associated with the outcome (TIP endorsement) using linear regression models or one-way Analysis of Variance (ANOVA) tests among those who self-identify as sexual minority men. Variables with \( p < 0.05 \) will be considered statistically significantly associated with the outcome and entered into a multivariable linear regression model. Such a model will be able to take into consideration multiple facilitators or barriers in predicting TIP scale scores at the same time. Collinearity between each significant variable will be assessed using Pearson’s Chi-square and Fisher’s Exact test, and the Hosmer and Lemeshow’s goodness of fit test will be used to evaluate fit of the final model. All statistical analyses were evaluated for statistical significance at alpha = 0.05, using two-sided tests and performed using R.

3. Results

The numbers of responses to each of the eleven TIP scale questions, along with the questions themselves, were recorded in Table 1. How each question was worded differently (i.e., implying trust or mistrust towards healthcare providers) were noted in further analyses. Table 2 gives the inter-item correlation coefficients between the eleven questions, which range from \(-0.284\) (between questions 5 and 6) to 0.510 (between questions 6 and 8). This range reflects that the items were reasonably homogenous while having sufficiently unique variance to achieve unidimensionality. Among all correlation coefficients that were significant at the 0.05 level, questions 6 and 8 (\(p = 0.510\)), 2 and 3 (\(p = 0.493\)), and 1 and 5 (\(p = 0.488\)) showed the three highest correlation coefficients. The wordings of these questions employed a non-directional language to include both positive and negative statements in the adapted TIP scale questions to reduce the risk of introducing systematic
TABLE 1. Counts and frequencies of endorsements of trust in physician scale items among young sexual minority men.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly disagree</th>
<th>Somewhat disagree</th>
<th>Strongly agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Q1.</td>
<td>53</td>
<td>29.61</td>
<td>42</td>
<td>23.46</td>
<td>15</td>
</tr>
<tr>
<td>Q2.</td>
<td>8</td>
<td>4.47</td>
<td>23</td>
<td>12.85</td>
<td>38</td>
</tr>
<tr>
<td>Q3.</td>
<td>11</td>
<td>6.15</td>
<td>18</td>
<td>10.06</td>
<td>32</td>
</tr>
<tr>
<td>Q4.</td>
<td>20</td>
<td>11.17</td>
<td>36</td>
<td>20.11</td>
<td>13</td>
</tr>
<tr>
<td>Q5.</td>
<td>16</td>
<td>8.94</td>
<td>30</td>
<td>16.76</td>
<td>20</td>
</tr>
<tr>
<td>Q6.</td>
<td>5</td>
<td>2.79</td>
<td>10</td>
<td>5.59</td>
<td>31</td>
</tr>
<tr>
<td>Q7.</td>
<td>32</td>
<td>17.88</td>
<td>43</td>
<td>24.02</td>
<td>14</td>
</tr>
<tr>
<td>Q8.</td>
<td>10</td>
<td>5.59</td>
<td>17</td>
<td>9.50</td>
<td>29</td>
</tr>
<tr>
<td>Q9.</td>
<td>6</td>
<td>3.35</td>
<td>17</td>
<td>9.50</td>
<td>34</td>
</tr>
<tr>
<td>Q10.</td>
<td>10</td>
<td>5.59</td>
<td>25</td>
<td>13.97</td>
<td>33</td>
</tr>
<tr>
<td>Q11.</td>
<td>50</td>
<td>27.93</td>
<td>36</td>
<td>20.11</td>
<td>11</td>
</tr>
</tbody>
</table>

TABLE 2. The inter-item correlation coefficients between the eleven trust in physician items. N = 179, NYC.

<table>
<thead>
<tr>
<th>Items</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>0.171*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0.122</td>
<td>0.493***</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>−0.029</td>
<td>0.315***</td>
<td>0.355***</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0.488**</td>
<td>0.162*</td>
<td>0.219**</td>
<td>0.001</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>−0.205**</td>
<td>0.169*</td>
<td>0.147*</td>
<td>0.222**</td>
<td>−0.284***</td>
<td>1.000</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>0.397***</td>
<td>0.021</td>
<td>0.054</td>
<td>−0.159*</td>
<td>0.328***</td>
<td>−0.153*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>−0.162*</td>
<td>0.092</td>
<td>0.084</td>
<td>0.177*</td>
<td>−0.076</td>
<td>0.510***</td>
<td>−0.118</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>0.004</td>
<td>0.299***</td>
<td>0.417***</td>
<td>0.293***</td>
<td>0.172*</td>
<td>0.003</td>
<td>−0.020</td>
<td>0.148*</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>0.110</td>
<td>0.281***</td>
<td>0.215**</td>
<td>0.169*</td>
<td>0.048</td>
<td>0.020</td>
<td>0.006</td>
<td>0.215**</td>
<td>0.431***</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>0.374***</td>
<td>0.065</td>
<td>0.119</td>
<td>0.016</td>
<td>0.335***</td>
<td>−0.213**</td>
<td>0.407***</td>
<td>−0.121</td>
<td>0.102</td>
<td>0.108</td>
<td>1.000</td>
</tr>
</tbody>
</table>

*p < 0.05, **p < 0.01, ***p < 0.001.
biases into the survey responses. The inclusion of both positive and negative inter-item correlations was an expected result of including both positive and negative statements in the TIP scale questions, indicating the validity of the survey responses.

### 3.1 Sample characteristics

Table 3 describes the sociodemographic characteristics of the sample. Among the 202 participants who completed the survey, we analyzed responses (n = 179) from cis-gender, SMM participants. Most participants were 26 years or younger (79%, n = 142). The majority of the sample were currently insured (85%, n = 152), Hispanic/Latinx (with any race) accounted for the largest (30%, n = 53) ethnic presentation, followed by non-Hispanic Black (29%, n = 52), non-Hispanic White (25%, n = 44), and non-Hispanic Other (17%, n = 30). Additionally, 42% (n = 71) of participants identified their preferred anal sex position as exclusively or primarily top, leaving 39% (n = 67) that exclusively or primarily preferred bottom and 19% (n = 32) who were versatile or had no preferred anal sex position.

A quarter (25%, n = 33) of study participants reported that they had used PrEP before, while nearly a quarter (24%, n = 42) reported they were actively on PrEP at the time they completed the survey. For the 152 insured participants, 59% (n = 90) and 41% (n = 62) received private and public insurances, respectively. For the 27 uninsured participants, 30% (n = 8) reported living without insurance within 3 months, 26% (n = 7) between 3 months and 1 year, 22% (n = 6) between 1 year and 2 years, and 22% (n = 6) more than 2 years, respectively. When asked about their self-rated health status, 89% (n = 160) rated their health as good and 11% (n = 19) rated their health as bad. Overall, nearly half of the sample (47%, n = 70) reported that they found it easy to pay for healthcare costs, compared to 30% reported difficulty and 25% reported neither easy nor difficult.

### 3.2 Trust in physicians reports

The participants reported an average cumulative TIP score of 37.4 (95% CI: (36.11, 38.59); SD = 8.42). Table 3 summarizes the uni- and bi-variate analyses where the cumulative TIP scale score was treated as the outcome variable. For all facilitators and barriers analyzed, simple linear regression models and one-way ANOVA tests were used, subsequently identifying that the TIP scores differed significantly by preferred anal sex position ($F = 3.443$, $p < 0.05$), insurance type ($F = 3.508$, $p < 0.05$), reported difficulty paying for healthcare costs ($F = 11.88$, $p < 0.001$), self-rated health status ($F = 9.356$, $p < 0.001$), and current PrEP use ($F = 8.403$, $p < 0.001$). Those reported being exclusively/primarily top or bottom in sexual encounters (n = 138), less difficulty paying for healthcare costs (n = 70), good self-rated health status (n = 160), having private insurance plans (n = 90), and were on active PrEP medications (n = 42) reported higher TIP scales.

The identification of multiple facilitators and barriers in predicting TIP scores among SMM is reflected in the application of a multivariate linear regression model. Such a model allowed for the analysis of the relationship between SMM’s endorsement of items on the TIP scale based on the specific sociodemographic and healthcare structural variables applicable, while adjusting for the simultaneous influence on the outcome. The model also allowed easily interpretable coefficients for each facilitator or barrier that gives a positive or negative value, correspondingly. The multivariate linear regression models were performed and are shown in Supplementary Table 1. When putting the five sociodemographic characteristics into one single multivariate linear regression model, being versatile or having no preferred anal sex position, not actively on PrEP, and being uninsured were statistically significant in predicting lower TIP scores, whereas exclusively or primarily topping in sexual encounters and reporting less or no difficulty paying for healthcare was statistically significant in predicting high TIP score.

### 4. Discussion

Trust in physicians is a critical component of both the patient-provider relationship as well as a facilitator to accessing healthcare services. Among young SMM, trust in physicians as well as the healthcare system more generally have served to reduce access to healthcare [29], limit disclosure of sexual orientation and behaviors [30], as well as ensure that the healthcare needs of this population are not met [23]. The findings presented here suggest that race, ethnicity, and sexual orientation were not significantly associated with trust in physicians; however, other sociodemographic characteristics such as preferred anal sex position, difficulty in paying for services, insurance and current PrEP use play a significant role in a patient’s trust in their physician.

While not commonly discussed in the relevant literature, preferred anal sex position as the top (insertive partner) and bottom (receptive partner) were associated with higher reported trust in physicians. In this study, lower TIP endorsements were found among participants who had versatile anal sex roles or didn’t have a specific anal sex role at all. This can be a result of how physicians adopt entrenched homophobic opinions, assuming SMM fall into exclusive sexual positions and correspondingly communicating differently with different sex roles. Such a disposition concurs with both heterosexist and sexist gender norms [31]. Recent studies have found that providers lack adequate training on the sexual health needs of sexual minority men as well as the lack of understanding of gay sex [32]. As a result, disclosure of a preference for versatile sexual encounters may be met with homophobic microaggressions that erode trust in physicians [31].

Financial concerns such as difficulty in paying for healthcare services and lack of insurance have long been associated with reduced trust in the healthcare system and more specifically physicians [33]. Furthermore, the inability to pay for care and not having health insurance are disparities that are highly reflective of being in a marginalized community with historical and ongoing health inequities [33]. Much of the extant academic scholarship focuses on discrimination based on race and ethnicity [34] and sexual orientation [34] but recent scholarship has illuminated the often-invisible economic discrimination faced by patients in lower socioeconomic groups [34]. Individuals that have experienced unsatisfactory or discriminatory healthcare interactions and are less likely to trust physicians themselves [24, 30].
### TABLE 3. Uni- and bi-variate analyses of endorsement of trust in physician items by subject sociodemographic. N = 179, NYC.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Univariate analysis</th>
<th>Bivariate analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N; n; Mean; %; Range, SD</td>
<td>Limited trust, N = 86; n; Mean; %; Range</td>
</tr>
<tr>
<td>Age</td>
<td>179; 26.2 (24.1, 28.2) (0.9)</td>
<td>26.1 (25.6, 26.7)</td>
</tr>
<tr>
<td>Age category</td>
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<tr>
<td>Younger than 27</td>
<td>179; 142; 79; 72; 84; 70</td>
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<tr>
<td>27 and older</td>
<td>37; 21; 14; 16</td>
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<tr>
<td>Race</td>
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<td>White</td>
<td>49; 27; 17; 29</td>
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<tr>
<td>Other</td>
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<td>179; 126; 70; 60; 70; 66</td>
<td>71; 66</td>
</tr>
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<td>27; 29</td>
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<td>Gay</td>
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<td>86</td>
</tr>
<tr>
<td>Bisexual/Pansexual/Queer</td>
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<td>13; 14</td>
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<tr>
<td>Preferred anal sex position</td>
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<td>Exclusively/Primary top</td>
<td>71; 42; 28; 35</td>
<td>39; 43</td>
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<tr>
<td>Exclusively/Primary bottom</td>
<td>170; 67; 39; 33; 41</td>
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<td>Versatile/No preference</td>
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<tr>
<td>Uninsured</td>
<td>27; 15; 14; 16</td>
<td>13; 14</td>
</tr>
<tr>
<td>Difficulty paying healthcare costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy</td>
<td>70; 47; 27; 40</td>
<td>18; 22</td>
</tr>
<tr>
<td>Difficult</td>
<td>149; 45; 30; 20; 29; 50</td>
<td>62</td>
</tr>
<tr>
<td>Neither easy nor difficult</td>
<td>34; 23; 21; 31</td>
<td>13; 16</td>
</tr>
<tr>
<td>Where to get healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care provider</td>
<td>158; 105; 66; 44; 61</td>
<td>61; 71</td>
</tr>
<tr>
<td>Non-primary care provider</td>
<td>53; 34; 28; 39</td>
<td>25; 29</td>
</tr>
<tr>
<td>Self-rated healthcare status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>179; 160; 89; 72; 84</td>
<td>88; 95</td>
</tr>
<tr>
<td>Bad</td>
<td>19; 11; 14; 16</td>
<td>5; 5.4</td>
</tr>
<tr>
<td>Currently on PrEP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>176; 42; 24; 13; 15</td>
<td>29; 32</td>
</tr>
<tr>
<td>No</td>
<td>134; 76; 71; 85</td>
<td>63; 68</td>
</tr>
<tr>
<td>Ever taken PrEP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>133; 33; 25; 22; 31</td>
<td>11; 17</td>
</tr>
<tr>
<td>No</td>
<td>100; 75; 48; 69</td>
<td>52; 83</td>
</tr>
</tbody>
</table>

*PrEP: pre-exposure prophylaxis; SD: Standard Deviation.*
Current use of PrEP as a facilitator of trust in physicians is a function of finding a provider who knows about the specific healthcare needs of SMM and is comfortable prescribing the medication [35]. Additionally, the requirements to continue PrEP use include additional testing and screening that necessitate more frequent visits to an individual’s healthcare provider as well as open and honest communication about sexual behaviors. In this way, PrEP acts as a conduit for increased disclosure and fosters patient—provider communication in a setting that is more likely to be LGBTQ-friendly [36]. Recent scholarship has found that patients who seek care from providers that are comfortable discussing and prescribing PrEP report higher levels of trust in physicians and greater satisfaction with healthcare services [36]. Overall, this study found preferred anal sex position, self-rated health status, insurance type, difficulty paying for healthcare services, and current PrEP uptake as predictors of endorsement of trust in physicians SMM.

Regarding limitations, the small sample size required that variables be dichotomized. For instance, anyone who did not identify as homosexual were grouped into an overarching category of bisexual, pansexual, and queer men. While this was done for statistical purposes, it undoubtedly obscures and limits the nuances of participant experiences. Additionally, since insurance type is only asked in terms of public or private, the impacts of various insurance (such as being on Medicaid) cannot be studied. Furthermore, the Patient Protection and Affordable Care Act allows dependents to remain on a parent’s insurance until the age of 26. Since we did not ask how insurance was obtained, it is possible that individuals on their parent’s insurance may not seek sexual health related services out of concern for accidental disclosure of sexual activity. Both limitations inhibit our ability to understand exactly how insurance may act as a facilitator or barrier to health services. Third, the nature of the data set and the cross-sectional survey does not allow to study trends over time or any causality. The sample population was also based in New York City, a location with a large concentration of health and community service organizations. It is also known to be more welcoming to the queer community than other regions of the country, with a long history of providing specialized health services. This may also have impacted the ability for this population to access care as well as increase comfort in disclosing sexual orientation and sexual behaviors to their provider. These factors may serve to promote trust in physicians. New York City also has a large number of public hospitals for those with or without insurance and also has several state-sponsored affordable insurance plans. This context may also have expanded the ability for this population to obtain care [37]. In addition, there have been numerous PrEP awareness campaigns conducted by the New York City Department of Health and Mental Hygiene such as the Stay Sure and Play Sure campaigns. Campaign posters were placed on the subway trains and bus shelters across NYC. Given the visibility of these campaigns, it is likely that this increased the awareness of PrEP among participants in our study and may have increased the acceptance and use of PrEP among our sample. Future studies should examine trust among young SMM who have significantly less access and exposure to public health messaging and PrEP access.

Furthermore, self-rated health care status was qualified as very bad, bad, neither good nor bad, good, and very good. In order to assess this data, it was dichotomized into “good” and “bad”.

Age of respondents (25–27 at time of data collection) may be an additional limitation to understanding the broader landscape of trust among SMM generally. Research has shown that trust in physicians does increase with age and length of time spent with a physician, therefore this study may have been impacted by the limited amount of years patients have spent with their providers [38]. Future research should assess how age and cumulative healthcare experiences may affect trust. Despite these limitations, this analysis reveals importantly relationships between specific demographic characteristics of SMM and different levels of trust in physicians.

4.1 Policy implications

Given the pace of new anti-queer and anti-bodily autonomy legislation that is the current state of reality in the U.S., this paper highlights the need for policy to protect the healthcare rights of the LGBTQ+ community. According to the American Civil Liberties Union, there were 510 anti-LGBTQ+ bills introduced in the U.S. in 2023. While not all of these bills will become law, the harmful effects remain. These laws function insidiously discouraging members of the LGBTQ+ community from seeking services, fostering a lack of trust between patient and provider, encouraging non-disclosure of sexual orientation and sexual behaviors, and reproducing shame and stigma among queer people. Each of these factors harm the health of LGBTQ+ identified people and deny their ability to fully express their identities within society. To protect the health of LGBTQ+ individuals, policy makers should sponsor bills that enshrine the healthcare civil rights of this population at the state level. Not only does this protect the health of the LGBTQ+ community locally, but it also protects Section 1557 of the Patient Protection and Affordable Care Act from legal challenges that could see this legislation be deemed unconstitutional.

4.2 Clinical implications

There is a number of implications of this study for medical providers who care for SMM. Individual clinicians and healthcare systems more broadly can make intentional efforts to earn the trust of SMM patients. Cost is increasingly a barrier to care in the U.S. for many patients, but disproportionately for minoritized groups such as SMM. Providers should learn about ways to mitigate financial barriers for patients (e.g., linking patients to safety net clinics and payment assistance programs for PrEP) and engage patients with multidisciplinary team members—such as insurance navigators and community health workers—who can help patients understand their eligibility for benefits like Medicaid. Clinicians can also advocate for a more equitable health care system that reduces barriers to care for SMM. Access to HIV PrEP remains inadequate for many SMM in the U.S., and lack of provider education is one important barrier. HIV PrEP training programs should emphasize the importance the primary care providers offer PrEP to eligible
patients, while highlighting the benefit of PrEP prescribing to the patient-provider relationship. Finally, the finding of reduced trust in physicians among patients with no preferred anal sex position suggests that medical providers need additional training on how to have affirming, non-judgmental conversations with SMM about sexual position.

5. Conclusions

The findings presented here shed light on the nuanced trust relationship between providers and young SMM patients. Furthermore, the results of this study enhance the literature around trust in medical settings as well as expanding the use of the TIP Scale to SMM populations. Findings can be used to inform future guidelines for provider training around the healthcare needs of SMM and racially diverse populations as well as the critical need to establish trust providers and patients of marginalized identities. Additionally, this study highlights the critical role of trust in physicians when considering the initiation of biomedical interventions such as PrEP. Moreover, this study highlights the need for additional research examining trust among queer femme populations as well as transgender and gender diverse individuals. This is critically important as states such as Tennessee work to actively harm the health of SMM through the elimination of Ending the Epidemic funding that provides critical HIV counseling and testing services. In political climates where access to publicly funded sexual healthcare services is determined by residence, physicians in private practice become essential to the provision of these services and trust in physicians is paramount for patient disclosure of sexual orientation, sexual behaviors, and sexual health needs.

AVAILABILITY OF DATA AND MATERIALS

The data presented in this study are available on reasonable request from the corresponding author.

AUTHOR CONTRIBUTIONS

J—designed the research study; performed the research. PNH—provided help and advice on the study design. YFL and MG—analyzed the data. YFL, MC, MG, JJ, TJ and BG—wrote the manuscript. All authors contributed to editorial changes in the manuscript. All authors read and approved the final manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Informed consent was obtained from all individual participants included in the study. The Study was approved by the Yale University (IRB 2000022607).

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found, in the online version, at https://oss.jomh.org/files/article/1818164278510665728/attachment/Supplementary%20material.docx.

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