Chapter 27
Case 9: Intimate Partner Violence in the Gay Community

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Case Scenario

A 19-year-old male presents to the emergency department with a complaint of painful rectal bleeding. The triage note is otherwise blank. The patient enters the examination room alone, appearing sullen and withdrawn. A young male resident assigned to his care becomes frustrated during multiple attempts at a history and a physical. The patient is quiet, slow to answer questions, and offers little detail. The resident makes several requests for the patient to fully undress. Physical examination is remarkable for a bloody laceration extending close to the ventral aspect of the anal sphincter. Multiple bruises are noted on the extremities. After the examination, the physician shakes his head and asks, "How did all this happen?" The patient starts to cry and states, "I can't believe my life has gotten so out of control."

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Review of Systems

The patient also reports nausea and anorexia, as well as painful defecation. He denies fever, cough, vomiting, headache, weight loss, and rash. All other systems are negative.

Past Medical History

Environmental allergies. No medications/allergies.

Family History

No history of inflammatory bowel disease or cancer.

Social History

The patient lives with his 34-year-old boyfriend. He denies tobacco use, but drinks alcohol heavily each weekend and uses illicit drugs: “My boyfriend gives me T to use sometimes.”

Physical Exam

Vital signs: Temp*:* 99.3, pulse 105, RR 22, BP 125/55, O_2 Sat 100 % on room air

General: Awake and alert, appears uncomfortable, poor eye contact

Cardiovascular: Tachycardic and regular; S_1 and S_2 normal, no murmurs

Respiratory: Breathing comfortably with good aeration, clear in all fields

ENT: Normocephalic, atraumatic; pupils equally round and reactive to light and accommodation, extraocular movements intact, anicteric; moist mucosa

Abdomen: Non-distended; normal bowel sounds; mild, diffuse tenderness to palpation without guarding; no peritoneal signs; no organomegaly or masses

Extremities: Warm, well perfused, full active range of motion; non-tender

Skin: Multiple areas of ecchymosis at bilateral wrists, proximal arms, and medial thighs

Neuro: Alert and oriented; cranial nerves 2–12 intact; strength and sensation 5/5 × 4; reflexes 2+ × 4; cerebellar and gait exams normal

Rectal: Tender 2.5 cm perianal laceration at 6 o'clock position; external sphincter tone intact; a small amount of fresh blood is present; vault empty, prostate non-tender

Questions for Discussion

1. Why wasn't the patient immediately forthcoming about the nature of his injuries?

Attitudes/Assumptions: The physician

(a) I know that there is something wrong, but how can I help him if he won't tell me what happened? This patient is wasting my time.
(b) I'm not surprised he's such a mess. I don't even know what drugs he is using … what does "T" even mean?
(c) I don't have time for something he brought on himself. If he is being abused by his partner, why doesn't he just leave?

Attitudes/Assumptions: The patient

(a) This doctor is going to judge me. I bet he is a conservative.
(b) If I tell the doctor that I'm using meth, he will report me and I will get arrested.
(c) I can't tell them that my boyfriend is beating me up. Men don't allow themselves to be beaten.
(d) If I tell them my boyfriend is beating me up, my boyfriend will get arrested.
(e) My boyfriend will really hurt me if he finds out I tried to get help.

Gaps in Provider Knowledge

(a) Lack of knowledge of health beliefs/customs: Drug use and depression are often associated with intimate partner violence (IPV) [1]. Methamphetamine, a highly addictive illicit drug, is associated with increased sexual drive and unsafe sexual practices [2]. "T" is one of the street names used for the drug [3].
(b) Lack of knowledge of community: Relative lack of awareness of IPV in general, particularly among same-sex couples. Gay men experience IPV at rates similar to or higher than those among heterosexual women [4], but can be hesitant to disclose due to social pressure [5]. The rates of IPV for women with same-sex partners and transgender individuals are even higher [5].
(c) Lack of knowledge of disparities/discrimination: Gay patients may be reluctant to discuss their sexual orientation or practices, given prior negative experiences with family and/or healthcare providers.

2. How could the physician more sensitively obtain a sexual history?

   Cultural Tools and Skills to Improve Communication

   (a) Questions about sexual orientation should be direct and free of judgment [6].
   - "Do you have sex with men, women, or both?" Do not assume heterosexuality.
   - Avoid labeling a patient as gay, lesbian, bisexual, or transgender, unless prompted by the patient. Some patients may avoid self-identification with a particular group and the term "men who have sex with men" (MSM) is more inclusive.

   (b) Sexual practices should be discussed in a "matter-of-fact" tone that conveys understanding: "There seems to be a tear at the opening to your rectum. Such injuries are commonly the result of trauma during anal sex or from the use of sex toys. Was anything put in your rectum that could have caused the cut I noticed?"

   (c) Details of possible IPV should similarly be solicited in a direct, yet supportive manner [6, 7]:
   - "Does your partner ever hit, kick, hurt, or threaten you?"
   - "Do you feel unsafe in any of your relationships?"
   - "Does anyone hurt you or force you to have sex?"
   - "Do you have a safe place to stay?"

3. What medical issues concern you about this patient?

   (a) Intimate partner violence, substance abuse, possible depression and/or suicidal ideation, anal laceration

4. Which components of the Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

   Medical Knowledge: The comprehensive care of this patient would require that the resident is well versed in the following topics: anorectal emergencies, substance abuse and addiction, depression and self-harm, IPV, and cultural competence with LGBT (lesbian, gay, bisexual, transgender) health issues.

   Patient Safety: Cases of IPV often require providers to address psychosocial issues as well as medical emergencies. This scenario tests the resident's ability to identify and manage cultural, psychiatric, and medical challenges in concert.

   Systems-Based Management: This case may require a resident provider to utilize multiple referrals for potential outpatient care (general surgery, addiction counselor or program, psychiatrist, STI clinic, shelter). Residents should become familiar with referral systems to such agencies in their communities.

   Professional Values: Providers often encounter patients with social or cultural practices that may conflict with the provider's own beliefs or values. It is

imperative that residents learn skills to care for patients in a manner that respects perceived differences and engenders a therapeutic environment.

Patient-Centered Communication: A professional and nonjudgmental approach is essential when obtaining a sexual history or eliciting experiences with IPV. The skilled resident would be able to tailor their questioning to the challenges of the case while ensuring a comfortable and trusting patient-physician interaction.

Case Outcome

Diagnoses: Anal laceration; IPV; substance abuse; depression
Disposition: Discharge with a supportive friend

The details of the patient's injuries are obtained in a supportive manner. As a result, the patient is comfortable relaying the details of his troubled home life to an understanding healthcare provider. The physician discusses the increased risks of self-injurious behavior, substance abuse, and partner violence among young gay men. The patient affirms that he is not suicidal and agrees to speak with a social worker regarding his partner's violence and unsafe living environment. He takes an outpatient mental health referral for possible depression. He receives appropriate STI screening and empirical treatment. A rapid HIV test is negative. The anal laceration will heal by secondary intention. The physician prescribes Augmentin, stool softeners, Sitz baths, and an outpatient surgery referral. The patient is given return precautions and is discharged in the care of a close friend.

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