Patients and Their Bodies: The Physical Exam

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Introduction

Chapter 4 reviewed the impact of trauma on the health of LGBT individuals. In this chapter, we will discuss how understanding trauma may be particularly relevant when conducting a physical exam with an LGBT patient. The laying of hands on the body to examine a patient has been a central part of medical practice for thousands of years and happens in most medical encounters [1]. While physical touch has the potential to be therapeutic and the exam may contribute to diagnosis and healing, it also carries the potential to harm. This is of particular concern for patients with a trauma history, where a history of physical, emotional, sexual, institutional, and healthcare-related traumas can make the physical exam more emotionally or physically challenging. Independent from trauma history, LGBT patients may find physical exams traumatizing if they seem incongruent with their gender identity (such as transgender women receiving a prostate exam). The experience of the physical exam can thus have negative consequences and, in a worst-case scenario, can trigger acute reactions such as dissociation or panic attacks. We review practical techniques of good clinical practice and positive patient-provider interaction that can make physical exams more empowering and prevent such adverse reactions; we also discuss how to manage these reactions when they do occur. Most of the literature on performing a trauma-informed physical exam concerns pelvic exams for individuals with natal female reproductive anatomy; where possible we also present evidence about other types of exams and guiding principles that can be generalized to many different exam procedures.

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Performing a Trauma-Informed Physical Exam That Is LGBT-Inclusive

See Table 16.1 for some guiding principles for performing a trauma-informed physical exam that is LGBT-inclusive.

Screen for Trauma

Screening for trauma is critical in the medical setting (see Chap. 14 for more details on how to build a trauma-informed practice). Even when a patient screens negative, the clinician can never be completely sure of the patient's trauma history, since not all patients who have experienced trauma recall the event or perceive events that are consistent with clinical definitions of trauma to be "traumatic." Others may make a conscious decision not to disclose. Therefore, it is important to avoid following one set of procedures for physical exams with patients who screen positive for trauma, and a completely separate set of procedures for those who screen negative. One should always act in a way that conforms to basic principles of trauma-informed care, though extra precautions to avoid retraumatization due to the exam can be taken with those who screen positive (see section "Additional Considerations for Patients Who Have Experienced Trauma").

K.L. Eckstrand, J. Potter (eds.), *Trauma, Resilience, and Health Promotion in LGBT Patients*,
DOI 10.1007/978-3-319-54509-7_16

Table 16.1 Guiding principles

1. Ensure that the *locus of control* remains with the patient – i.e., that the patient feels they have voluntarily consented to the exam and feels empowered to stop the exam, communicate with you, or ask for modifications at any time
2. Engage in *shared decision making* regarding what screening the patient opts to do, especially in the face of uncertain evidence or conflicting guidelines
3. *Explain* the procedure to the extent preferred, using the patient's preferred terminology for body parts
4. Discuss what *modifications to the exam* can be made to promote patient comfort
5. *Acknowledge* the patient's trauma history and *validate* any negative consequences they feel resulting from the trauma

Consider if You Actually Need to Perform the Exam

Although most patients will not be traumatized by a physical exam, any exam has some potential to be traumatizing. This is especially true if the exam requires the patient to become particularly vulnerable (as during a breast, pelvic, prostate, or rectal exam) or if the patient has a history of trauma of any kind. Posttraumatic distress can be triggered even years after the index traumatic event by strong emotions (e.g., feeling helpless, out of control, trapped, or unprotected), physical discomfort, and/or any sensation that is reminiscent of the original trauma. Because all aspects of the physical exam have the potential to cause such harm, it is important to avoid asking patients to submit to exams that are not clearly warranted – especially those aspects of an exam that cause the greatest vulnerability.

Review the evidence in your specialty for what aspects of the physical exam are supported by reliable and consistent evidence, and which are not. For instance, the American College of Physicians conducted a systematic review and in 2014 concluded that there is no evidence to suggest that routine screening with bimanual examination (BME)[1] for asymptomatic, average-risk, nonpregnant women reduces morbidity or mortality as long as cervical cancer screening guidelines are followed [2], with some calling BMEs "more of a ritual than an evidence-based practice" [3]. Nevertheless, many gynecologists continue to regularly perform this exam on asymptomatic patients [4, 5]. Similarly, testicular exams are no longer recommended to screen for testicular cancer in asymptomatic adolescent or adult individuals with natal male anatomy [6]. In another example, the US Preventive Services Task Force (USPSTF) ruled in 2009 that there is insufficient evidence to suggest any benefit to clinical breast exams above and beyond mammography as a screening procedure for breast cancer, and also recommends against teaching breast self-exams [7], as does the American Cancer Society [8].

If you are in the middle of a visit and are not sure whether a particular screening exam is indicated, let the patient know you need to obtain consultation to determine the most up-to-date medical recommendations, and step out of the room to confer with a knowledgeable colleague in the moment. If such guidance is not immediately available, set an intention with the patient to complete the discussion at their next visit rather than proceeding with the exam, particularly if the exam has a higher potential to be traumatizing (e.g., breast, pelvic, prostate, or rectal exams).

Completely unnecessary exams must be avoided. For instance, asking to see trans patients' body parts merely out of curiosity about anatomical changes or surgical results is unprofessional and a form of harassment. In a qualitative study we conducted, one patient recounted a story of a surgeon who, while preparing to perform a breast augmentation for a trans woman, asked to see her vagina because he was curious about what it looked like [9]. This sort of curiosity is never appropriate.

Consider if There May Be Alternative Procedures to Recommend to or Offer the Patient

Increasingly, alternatives exist to physical exams that are backed by evidence and may be preferred by some patients. For instance, self-collected swabs for gonorrhea and chlamydia testing, including vaginal, anal, and throat samples, are actually superior to physician-collected samples in their sensitivity and specificity [10]. While some patients will prefer to have a provider collect the sample, others will appreciate having the option to perform sample collection themselves.

Make No Assumptions About Patients' Preferences and Discuss the Benefits, Potential Harms, and Limitations of the Examination, Particularly with Regard To Data Pertaining to LGBT Populations

After reviewing the benefits and risks of exams to decide whether they are indicated (see section "Consider If You Actually Need to Perform the Exam"), the clinician should engage in shared decision making with LGBT patients about whether to perform the exam. Involving the patient in this decision helps the locus of control remain with the patient

[1] A bimanual examination is when the clinician places two fingers inside the vagina and the other hand on top of the abdomen in order to palpate internal pelvic structures such as the cervix, uterus, and ovaries.

and helps ensure that they fully understand and consent to the exam.

This discussion should include a review of data (or lack thereof) pertaining to benefits and risks in specific LGBT communities, especially transgender patients, for whom high-quality evidence is frequently limited. For instance, no studies have specifically evaluated the benefits and harms of clinical breast exams, mammography, testicular or prostate exams, and Pap tests of the neovagina among postsurgical trans women. In the absence of definitive data, expert consensus recommendations are available to guide care [11–13]. For example, the University of California San Francisco (UCSF) Center of Excellence for Transgender Health recommends against performing Pap tests of the neovagina in trans women because its walls are typically composed of keratinized skin or urethral/colon mucosa and recommends screening mammograms for trans women 50 or older with more than 5 years of estrogen and progesterone use and additional risk factors (family history, BMI $>$ 35) [14]. While recommended exams should be promoted, patients should nevertheless be made aware of the quality of the evidence that underlies such consensus recommendations.

This discussion should also review potential harms of the exam, which include the possibility that it may cause emotional distress and/or physical discomfort. After validating the patient's concerns, discuss modifications that can be made to the exam to make it more acceptable to the patient (see section "Before Proceeding with the Exam, Discuss Whether the Patient Desires Any Modifications to the Exam to Reduce the Potential for Retraumatization"). If an exam is clearly indicated, it is the clinician's job to help the patient feel comfortable enough to adhere to the recommended guidelines as closely as possible. However, this should never be accomplished at the expense of true informed consent. In our qualitative work with transgender men, several reported being told they could not obtain hormones if they did not first agree to have a cervical Pap [15]. This echoes the outdated practice of withholding birth control if the patient has not had a Pap test [16], another coercive and medically unsupported practice.

In addition, clinicians should avoid assuming that either discussing the physical exam in advance or performing the exam will necessarily cause psychological harm, and should refrain from broaching the topic of an exam with exaggerated caution. Some LGBT patients may have extra sensitivities or concerns about an exam while others may not. Simply ask about a patient's prior experience with similar exams, and find out which aspects went well and which could be improved in the future.

Before Proceeding with the Exam, Discuss Whether the Patient Desires Any Modifications to the Exam to Reduce the Potential for Retraumatization

Explain to the patient what they can expect in terms of length of time the exam will take and what sensations or discomfort they may experience. To the extent preferred, explain the mechanics of the exam (e.g., offering to show a speculum before a Pap test if they would like to know the details). These conversations should take place while the patient is still clothed and in a location where the patient is empowered to participate in such a conversation [17].

Discuss potential modifications to the exam to increase individual comfort. In a qualitative study of transgender men's preferences with regard to cervical cancer screening, patients reported a wide range of comfort with the exam and many found modifications helpful [15] including:

1. Self-insertion of the speculum
2. Use of a pediatric speculum
3. Use of lubricant and/or topical lidocaine to ease speculum insertion
4. Having a trusted support person accompany them as a chaperone
5. Positioning alternatives
6. Use of antianxiety medications

Allowing the patient to make modifications to reduce physical and/or emotional discomfort with the exam shifts the locus of control toward the patient and makes retraumatization less likely. Alternative positioning diagrams and descriptions are available elsewhere [18]. Different patients will have different preferences, so asking the patient "What we can do to make this exam easier for you?" and briefly providing some options to open up the discussion is important. Regardless of trauma history, modifications can make the exam more tolerable for any patient.

It is extremely important that the locus of control with respect to both proceeding with an exam and stopping the exam at any point resides at all times with the patient. Review with the patient that it will always be their choice whether and when to proceed with an exam and that they retain the right to change their minds at any time and stop the exam. If choosing to proceed, agree in advance on the signal the patient will use to indicate that they want to stop the exam and be sure to respect that signal immediately.

Always Obtain Assent Before You Physically Touch or Examine a Patient

Prior to performing any aspect of a physical exam it is important to explain to the patient what you plan to do and obtain assent. For example, one might say, "Now that we've completed your history, I'd like to check your blood pressure and listen to your heart and lungs... Is that OK?" Once a patient has assented, it is important to continue to provide verbal notice before touching the patient; for example, one might say, "Now you'll feel the stethoscope touching the right side of your back." When performing a particularly sensitive exam that involves touching vulnerable parts of the body (e.g., the genitals), provide a warning before each maneuver ("Now I'm going to separate the outer folds"... "Now you'll feel a little pressure as I insert the speculum"). These warnings help patients prepare themselves so the touch does not come as a surprise and cause a startle response. It may be helpful to students just learning these techniques to perform the exam as if the patient cannot see what is going on, as in this case explaining every action prior to doing it comes very naturally. As many members of the treatment team (e.g., medical assistants, nurses, etc.) may have occasion to touch patients in the course of providing care, it is important to teach all team members these trauma-informed exam techniques and to observe their performance to make sure they achieve the desired level of competence.

Non-gendered or less-gendered terminology can be particularly important to use with transgender patients who experience body dysphoria unless they indicate a preference for traditional clinical terms, e.g., using "folds" instead of "labia" when performing pelvic exams with transgender men. Language with sexual ("I'm going to come into you now") or violent connotations (such as "blades" of the speculum) should be avoided. See Potter et al. [15] for alternative language suggestions.

Particular sensitivity is required in situations in which extra caregivers, such as translators, American Sign Language (ASL) interpreters, personal care attendants, etc., are present in the exam room. In these cases, you should discuss how the patient wants or needs the exam to be conducted (e.g., with the translator in the room but standing behind a curtain, using hand signals agreed upon in advance and the ASL interpreter stepping outside the room, etc.) before proceeding [17]. These steps are particularly important when caring for patients with a known trauma history and for transgender patients, who may be more likely to experience additional people in the room as voyeurs.

During the Exam, Be particularly Mindful of Your Tone and Reactions

The patient may feel most vulnerable during the actual exam itself due to physical positioning or touch and thus may be most sensitive to triggers at this time. Speak and move calmly and slowly, as these actions will help both you and the patient remain calm during what can be a stressful situation for both parties. Avoid expressing surprise or making any remarks during the exam about the patient's body that are not relevant to the performance of the exam. For instance, some trans patients may have anatomical changes as the result of hormones or surgery, while others may not. In a qualitative study of trans men's experiences with cancer screening, one participant reported feeling disturbed when a clinician commented during an exam of his postmastectomy chest, "I bet you were happy when those were gone!" While the clinician may have been trying to build rapport by validating the patient's decision to have gender-affirming chest surgery, the comment was medically unnecessary, made the patient feel like an object of scrutiny, and drew attention to a part of their body that had been the focus of considerable dysphoria in the past. Body piercings or tattoos should also not be commented on unless medically relevant.

Additional Considerations for Patients Who Have Experienced Trauma

While the above steps apply to all patients, additional steps may be necessary for patients with a history of trauma who are having a difficult time approaching the exam.

Validate the Patient

Normalize that many people have an impulse to avoid exams in the wake of trauma. Emphasize the importance of locus of control and of accomplishing needed exams as a key ingredient to self-care.

For patients who have experienced violence and abuse, self-care may seem like a foreign concept, exhausting to contemplate or pointless to consider. Gently remind such patients that everyone deserves to be cared for, we all have the power to take care of ourselves, and caring for one's body is an important aspect of healing from trauma and abuse.

Be Patient and Focus on Building a Relationship

In our qualitative work with transgender men and cervical cancer screening, an established, trusting relationship with the provider was a key facilitator to screening: many patients were unwilling to receive a cervical Pap test with a new provider, but were willing to do so once trust was established. Supportive and gentle encouragement by a provider repeatedly over multiple visits can enhance a patients' intrinsic motivation to undergo a needed procedure, despite initial reluctance.

Brainstorm Additional Ways to Support the Patient

When working with patients who have experienced trauma, it is particularly important to discuss adaptations to the exam that can be used to optimize comfort. These adaptations are analogous to the accommodations you would make for any patient who has additional needs that must be addressed in order to perform a thorough exam (e.g., a patient with an above-the-knee amputation who is unable to place both lower extremities in footrests for a pelvic exam and requires collaborative problem solving to achieve a comfortable and feasible position in which the exam can be performed successfully). Such time spent up front can be pivotal in establishing an environment in which the patient eventually feels sufficiently safe to proceed with the exam. It is often useful to devote an entire visit to this discussion to allow enough time to discuss concerns and preferences, and to not rush the patient. In our qualitative work, transmasculine patients who were reluctant to undergo cervical cancer screening often expressed the desire for a consult visit where they would be able to talk to the provider about what the procedure would entail and how to manage challenges that might occur during the exam, such as emotional and/or physical discomfort. This approach further allows for patients to prepare themselves for a subsequent exam and to feel more in control of the process.

Discuss potentially pursuing a team-based approach to accomplishing the exam, such as involving a therapist in helping the patient learn techniques to manage discomfort and/or inviting a supporter of the patient's choosing to attend the exam. If participation of an office assistant or chaperone is anticipated, an explanation of the reason for that person's attendance is crucial. Some patients may feel more uncomfortable undergoing certain exams in the presence of chaperones as they can feel like a voyeur [15]; therefore, whenever possible, the patient should be given the choice of whether to have one.

For some patients, premedication with a short-acting anxiolytic medication (e.g., benzodiazepine) may also be helpful. Keep in mind that such medicines may cause dissociation during the exam or even amnesia, which may be alarming to patients who have experienced trauma [19]. When using such medicines, it is therefore a good idea to discuss these side effects with patients prior to their administration. Again, inviting a person the patient trusts to witness the encounter if medication is used can create a space that feels more safe [15].

Patients who have experienced trauma in the past may be more likely to experience physical pain due to factors such as anxiety leading to involuntary pelvic floor muscle contraction and/or spasm, which can also impede insertion of specula or digits in the case of pelvic and rectal exams. Strategies to reduce pain include application of topical lidocaine gel for vaginal or rectal exams, topical nitroglycerin for rectal exams, and oral anesthetic spray for pharyngeal swabs. Postmenopausal women and transgender men on testosterone may also benefit from a 5-day course of estrogen or suppository prior to a pelvic exam to reduce atrophy-mediated discomfort upon speculum insertion. Transgender men may have some sensitivities around using estrogen cream, so the discussion should be broached thoughtfully, emphasizing that the effects are highly localized and short term.

Be Prepared to Handle Dissociation or Distress During the Exam

If a patient seems to be experiencing mild distress during the exam, even if they have not signaled or asked for you to stop, ask the patient if they would like you to do so. Some patients will prefer to continue and get the exam over with despite some distress (particularly if the only distressing aspect is physical pain and not emotional distress), while others will appreciate the opening to ask you to stop. If a patient is having more severe distress or dissociates during the exam (e.g., eyes become glazed, stares off into space, seems to no longer be engaged in the present, begins to cry, or has a flashback), stop the exam immediately. Have the patient sit up fully covered, and utilize grounding techniques. These are techniques designed to bring the patient back to the present:

- Verbally reorient the patient using safety statements ("I am Dr. XX"... "You are safe right now"... "You are in the present, not the past"... "You are at ___ and the date is ___").
- Ask the patient to keep their eyes open and look around the room. Ask the patient to describe the exam room in detail using all of their senses (e.g., objects, sounds, textures, colors, smells, shapes, numbers, temperature).
- Reconnect the patient with their body by asking them to grip the table as hard as they can with their hands, wiggle their toes in their socks, or place their feet on the floor and literally feel the ground supporting them.
- Once the patient is reengaged in the present, and preferably when they are once again fully clothed, talk about what happened, reassure the patient that such reactions are common and make sense after a person has experienced trauma. Reassure the patient that they did not "fail" in some way, that you are not upset that they were not able to complete the exam at this visit, and that you are invested in continuing to work together to make sure they receive the best possible care.

Debrief After the Exam and Make Sure the Patient Has a Plan for Self-Care After Leaving the Office

For patients who experience distress during the physical exam, always conclude the encounter by assisting the patient in reconstituting and developing a self-care plan for after they leave the office. This plan might include:

- Connecting with a therapist, friends, family, or pet
- Picturing themselves in a safe and soothing place (e.g., the beach, mountains, or a favorite room)
- Repeating a coping statement ("I can handle this"... "This will pass"), poem, or prayer
- Self-soothing by setting an intention to give themselves a safe treat (e.g., nice dinner, warm bath, listening to favorite music, etc.)
  - If they feel their gender identity was undermined by the exam (e.g. some transmasculine patients report feeling their identity feels challenged or destabilized after undergoing a Pap test), they may want to make a plan for affirming their gender in positive ways (e.g. one patient in our qualitative study reported going shopping for men's clothing and asking his friends to text him and call him "handsome" after his Pap test).

Make sure the patient has a follow-up appointment scheduled before they leave the office. If possible, give the patient a transitional object to take home – such as a business card with your name and contact information on it – to help them stay tangibly connected.

Case Example

The patient is a 55-year-old woman who is brought in to your office by a female friend. She does not make eye contact with you as you attempt to make introductions but answers all of your questions, and you learn that she goes by "Mary," identifies as a lesbian, and uses the pronouns "she/her"/"hers." When you ask what brings her in today, she hesitates initially and then says after encouragement from her friend: "I've been having bleeding down there." With supportive prompting, you learn that she underwent menopause at around age 50 but has been having erratic, sometimes heavy vaginal bleeding for the past 6 months. She admits that because of a history of childhood sexual abuse, she has always hated having her vagina penetrated with any object, including tampons, fingers or toys during sex, or the device doctors use during a pelvic exam. In fact, her last attempt to have a Pap test more than 15 years ago was unsuccessful because she developed extreme pain on insertion of the speculum. After that experience, she made a decision to avoid medical care altogether "unless it's an absolute emergency."

Discussion Questions

- What exams are warranted in this case?
  - Visual inspection of entire perineum, speculum exam of vaginal vault and cervix with cervical Pap test, and bimanual palpation.
- How will you prepare the patient for the exam given her reluctance?
  - Explain time frame for the exam: 3–5 min
  - See example introductory language below for points you may want to consider discussing.
- What strategies can you use to adapt the exam to optimize comfort?
- If an exam cannot be performed due to patient preference, what else can be done to evaluate her chief complaint?

Example Introductory Language to the Physical Exam

Having explained the general principles to follow, here we provide example language adapted from a script developed for our work providing cervical Paps to transgender men [20]. *The provider uses gender-neutral language and open-ended questions to explain the exam to the extent preferred by the patient, check in about past experiences with the Pap, offer a number of modifications, and allow space to discuss, validate, and address patient concerns. This script can be adapted for other types of exams.*

- In a moment, I'll step out to let you get ready for the examination. Before I do that, I wanted to make sure that you understand the examination. What terms would you prefer I use or avoid when discussing your body?
- The Pap test looks for cells from the cervix that appear to be abnormal and might be a sign of a cancer developing so that we can monitor closely or treat any abnormal cells found in order to prevent cancer. The cervix is an internal organ located at the end of the frontal canal [or patient's preferred term for vagina]. During the exam, I use a tool called a speculum to widen the [patient's preferred term for vagina] so I can insert a small spatula and then a brush that collect cells from the inside and outside of the cervix.

The process usually takes about 5 min. We send the cells to a lab for further testing and get the results back in about 2–3 weeks.

- [When appropriate, e.g., for patients aged 30–65]: Because we know that infection with the HPV virus can trigger cells to start growing abnormally and possibly turn into cancer, the lab will also test the samples we collect today for HPV.
- If any of the tests we do today are abnormal, we will help you arrange further testing or treatment.
- Have you had a Pap test before? [If yes] What aspects of the procedure were difficult or that you would like to do differently this time? [Discuss with patient; offer modifications that address their specific concerns].
- Traditionally, when a pelvic and Pap test are done, the patient lies on their back on the exam table with their feet in these footrests, but you can choose a different position if you wish. Some people prefer to have their feet flat on the end of the table; other people lie with the soles of their feet together and their legs out in a frog-like position. Some people prefer to have the top of the exam table raised up a bit so that they can see what is going on during the examination. How would you like to be positioned for the examination?
- Some people also find that they have discomfort when the speculum is inserted and that it helps them to insert the speculum themselves with my guidance. Is this something that you would like to do or try?
- Sometimes people want another person, perhaps a friend or another medical professional, in the room during the exam. Who, if anyone, would you like in the room to be with you while you are having the examination?
  OR: Usually when I perform this exam, I have a medical assistant in the room with me who helps hand me the tools I need. How would you feel if he/she/they were in the room during your exam?
- Before we do the exam, would you like to see the speculum and the swabs and brushes that we use?
- Would you like me to talk you through what I'm doing as the exam goes along or would you prefer that I remain silent?
- Finally, I want you to know that you are in control of the examination. If at any point, you would like me to pause or stop the examination for any reason, just let me know. You can tell me to stop or simply hold up your hand, and I'll check in with you about what you want to do. How does that sound?
- What other questions do you have before the exam?
- Great, I'll leave now and give you a few minutes to change. Please take off your pants and underpants, put on this gown, and sit on the end of the table with this sheet over your lap.

Performing a Physical Exam in the Immediate Posttrauma Setting

Clinicians may be called upon to perform a physical exam immediately after a patient has experienced trauma, including physical or sexual child abuse, elder abuse, intimate partner violence, or hate crimes. These can be some of the most difficult exams for a person who has a history of trauma, and there are special considerations for LGBT survivors. As a case example, we focus in this section on how to make sexual assault forensic exams (SAFEs) trans-inclusive. We do not attempt to provide a comprehensive tutorial for performing a SAFE exam, but instead focus on aspects of the exam that require special consideration in transgender patients. The principles discussed here extend to other LGBT populations, types of trauma, and types of physical exams immediately after a traumatic event.

The goal of a SAFE is to provide medical care, including treatment of injuries, postexposure prophylaxis of sexually transmitted infections, and emergency contraception as relevant, and to document evidence that can be used if the patient decides to report to law enforcement. SAFEs are usually conducted by sexual assault nurse examiners due to the specialized nature of evidence collection, but clinicians working in an emergency department or primary care setting also may need to provide acute care to someone following an assault [21].

Special Considerations: Data, Disparities, and Context

Members of LGBT populations experience sexual violence at rates comparable to or higher than their heterosexual, cisgender counterparts (see Chap. 18). Best estimates suggest that some 50% of transgender people have been sexually assaulted [22].

Trans survivors of sexual violence often report that anti-trans bias was a key factor that motivated the assault. In a 2005 survey by FORGE, 42% of survivors reported that their assault was motivated at least in part by their gender [23], while in a study of transgender people in Virginia, 71% of transfeminine survivors and 40% of transmasculine survivors felt they had been targeted due to their gender [24]. Hate and bias-motivated crimes generally result in greater psychological trauma than non-bias crimes as the person's sense of themselves, their identity, and their community is also under attack [25]. Thus, transgender survivors of sexual violence are more likely to have to cope with the fact that their identity was under attack than would cisgender survivors. Transgender survivors of color also have to grapple with the sense that they were targeted because of their

intersectional racial and gender identities; a review of anti-trans hate crimes in Los Angeles found that many perpetrators expressed both racialized and anti-LGBT slurs [26]. In addition to more complex emotional scars, assaults motivated by animus toward transgender individuals often leave more complex physical scars as well, as hate crimes motivated by anti-LGBT bias tend to be more violent than hate crimes against racial or religious groups [27], and injuries may be more likely to include disfigurement to the face, chest, genitals, or other gendered body parts [28]. The nature of the attack may be otherwise tied to gender, as when one transgender woman was beaten using her own high heels [26]. In order to fully support transgender patients, clinicians should educate themselves about federal hate crime laws, just as they should seek to be informed about the Violence Against Women Act (VAWA) and reporting considerations for cisgender women.

Receiving a full-body exam, including a pelvic exam, immediately after a sexual assault can be traumatic. Further complicating post-assault care, transgender survivors may have to deal with the simultaneous challenge of reentering the healthcare setting where they have also experienced trauma in the past. The National Transgender Discrimination Survey found that 10% of respondents had been sexually assaulted by a healthcare provider, 26% had been physically assaulted by a medical provider, and 19% had been denied medical care because of their identity [29]. These numbers may be higher among transgender people of color [30]. This context may make the physical exam feel overwhelming. Data about to what degree transgender survivors are able to access SAFEs specifically are not available, but disparities in accessing healthcare due to either avoidance or being denied care may carry over to SAFEs as well. Due to the importance of forensic evidence in prosecuting sexual assault, transgender individuals may be more likely to be assaulted, less likely to receive a SAFE, and less likely to receive justice.

Special Considerations: Administrative Issues, Forms, and Interacting with Others Besides the Patient

As with general intake forms, care should be taken to use forms related to the exam that accommodate a range of gender identities and sexual orientations. Despite the best forms, however, a trans person may or may not indicate their identity on intake forms, particularly if they are accompanied by someone who does not know they identify as trans. During an exam, it is important to avoid expressing surprise or alarm if body parts are not concordant with what you expected based on the intake.

As with any SAFE exam, take the initial assault history in private, away from any support person. If the patient requests the presence of a support person during portions of the history and exam, ensure that exam findings are not shared with the support person without the patient's knowledge and consent. Keep in mind that any person accompanying the patient – regardless of the gender of this companion – might actually be the person who abused the patient. Also, do not disclose to the support person that the patient is trans unless the patient explicitly gives permission to do so.

An important part of the SAFE involves marking a body diagram for where the patient has injuries. Use a gender-neutral diagram such as the one in Fig. 16.1. If your organization or state requires the use of gendered body maps or forms, or such forms are necessary to best document injuries from the assault, then explain to the patient why you are required to use such forms, and explain that this is not done to disrespect their gender identity. These explanations can minimize distress caused by forms that are not inclusive.

If consultation with or referral to an outside provider is necessary for follow-up, the patient may be anxious about having to meet with a new provider and once again disclose that they are transgender. Where possible, identify providers in your area in advance who have experience working with transgender patients, so you can assure the patient that the providers will be both welcoming and knowledgeable. Offer to assist the patient in informing the consultant of the patient's gender identity in advance, if the patient would find this introduction helpful.

Special Considerations: Clinical Considerations for Trans Patients

Be aware of anatomical changes that trans people may have as a result of hormones or surgery, and common physical findings that results from practices such as chest binding (compressing chest tissue for a flatter appearance) or genital tucking (pushing the testes into the inguinal canal and the penis between the legs). For instance, chest binding can result in scarring, abrasions, rashes, and cuts to the torso [31], while tucking may cause defects or hernias at the external inguinal ring [32]. This background helps the examiner evaluate what may be normal for the patient and what may be related to the assault. However, make no assumptions and nonjudgmentally ask the patient whether abrasions, cuts, and other physical findings are assault-related. For example, rather than assuming that cuts on the chest are from chest binding – or from self-harm practices, which are relatively common in this population [33] – nonjudgmentally ask how long the person has had the cuts [28] and where the cuts come from. Document all injuries

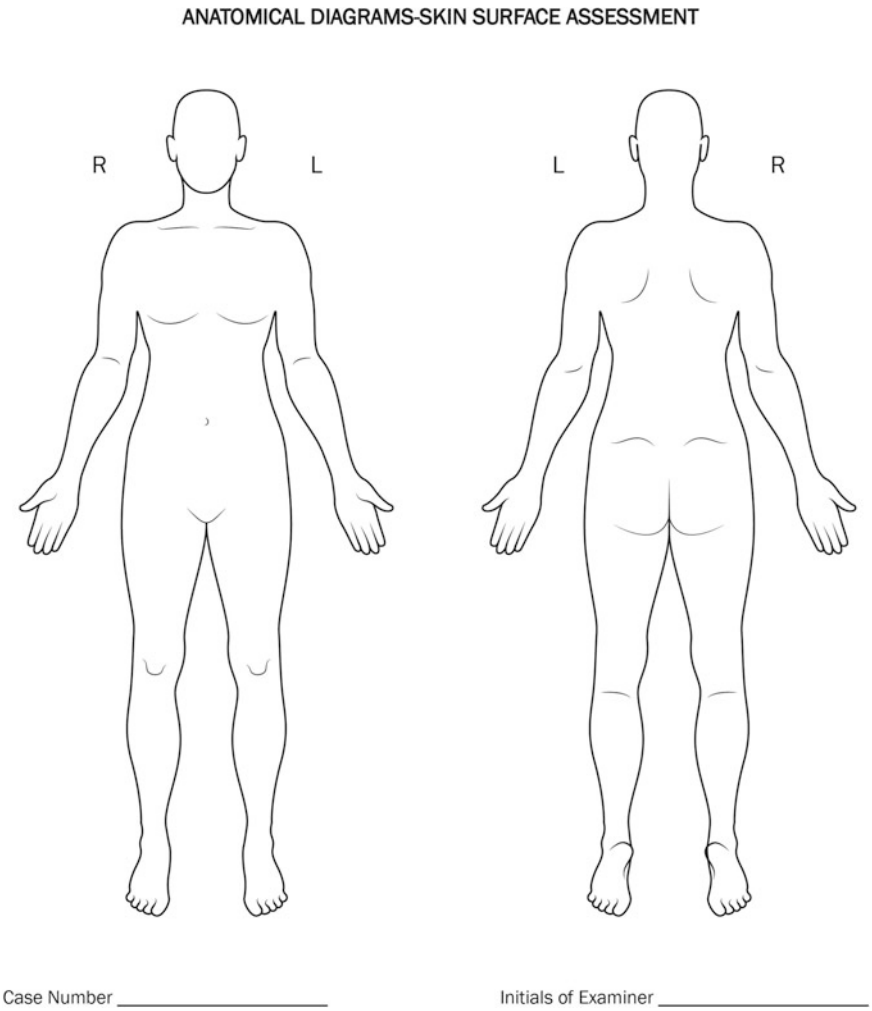

Fig. 16.1 Gender-neutral body diagram for use documenting injuries in post-assault exams

[34], including details such as the location, size, number, color, and depth of injuries. Use imaging studies where clinically appropriate. The role of the clinician is not to judge whether an assault occurred [21] or to use legal terms in the patient record (e.g., "patient alleges") but instead to document in detail the injuries present and information reported by the patient.

Trans men on testosterone experience vaginal atrophy and the vaginal wall becomes less elastic, more fragile, and prone to perforation [35, 36]. For trans women who have had genital reconstruction, the neovagina is also often less elastic than a cisgender woman's vagina [32]. While data are not available, trans individuals may therefore be more likely to experience genital injuries during a sexual assault, which may make acquisition of HIV/STIs more likely. During a pelvic exam, it also means that a pediatric, shorter-billed or narrower speculum may be necessary during the exam to avoid further trauma [28]. For neovaginal exams, consider using an anoscope rather than a vaginal speculum, as the neovagina has an inferior angle and lacks fornices and a cervix.

While numbers are hard to obtain, particularly for transgender individuals, anal penetration is likely more common among sexual assault survivors with natal male anatomy than among cisgender female survivors of sexual assault; in one study of gay and bisexual male survivors, 45.2% were anally penetrated [37]. Particular attention to anorectal trauma may therefore be warranted.

Trans men may not be aware that they can become pregnant as a result of penile-vaginal penetration, even if they are on testosterone and are experiencing amenorrhea [38]. It is the examiner's job to sensitively counsel the patient that pregnancy is a concern in this context if the patient has not had a hysterectomy and is not using birth control. The examiner should explain the options around emergency contraception (EC). Be aware that some patients may be reluctant to take estrogen or even progesterone-containing pills, either because the idea conflicts with their gender identity, or because they are concerned that these hormones will inhibit or conflict with testosterone therapy. There are no known contraindications to giving oral EC to patients on testosterone, though this practice has not been studied in transgender

men specifically [38]. Explain that commonly prescribed oral EC methods do not contain estrogen and are either progesterone-only or contain ulipristal acetate. The copper IUD contains no hormones and thus may be a more palatable form of emergency contraception for some patients. There is no need to halt testosterone use in transgender men receiving emergency contraception [28].

For trans women who use silicone injections, physical assault may dislodge silicone deposits, which can be dangerous [28]. As mentioned earlier, assailants may particularly target gendered body parts where silicone injections are commonly used, such as buttocks, breasts, and face; therefore, these areas should be carefully examined and any injuries documented.

Be prepared to arrange specialty consultation if there is damage to the neophallus or neovagina that requires surgical repair beyond your ability. Ideally, make a standing arrangement with a surgeon in your area, so that you do not need to rush to find someone when presented with a patient in a crisis. You may also need to consult with the surgeon who performed the original operation on a particular patient, with the patient's consent [28].

Prosthetics can have evidentiary value and patients should be asked to bring prosthetics in for evidence collection if they were worn during the assault [34]. While generally clothing is taken and submitted as evidence for testing, there may be special sensitivities toward taking prostheses, wigs, and other gender-related items from the patient. First, these can be expensive to replace. Second, leaving the facility without these items can leave a patient emotionally and/or physically vulnerable, particularly if they feel they need to "pass" for safety. If the patient feels strongly that they need to keep a prosthetic, try swabbing or collecting samples from the surface of the item rather than taking the item entirely, if possible. Regardless, counsel the patient on how to access victim compensation funds to replace prostheses that are damaged or submitted as evidence. If possible, have extra wigs or prostheses available for the patient to take with them, and makeup available for trans women to use before leaving if desired. Most facilities that perform SAFEs have underwear and clothing available for patients after a SAFE, and having these additional items can be important in facilitating evidence collection and promoting the patient's mental health and safety after the exam [28].

Special Considerations: Patient-Provider Interaction

Clinicians should take special care to explain what they want to do and why they want to do it before each step of the exam, giving the patient the opportunity to ask questions or deny a specific procedure before proceeding. While providing a detailed explanation is important for any patient, experiences of being treated as a medical or anatomical curiosity and mistrust of healthcare system in general make this practice particularly critical for transgender clients. Specific aspects of a SAFE may be particularly important to explain to trans patients; for example, having body parts photographed can be important from a legal perspective, but may make a patient feel that they are being subjected to unnecessary scrutiny unless properly prepared as to why this step is necessary.

Before the patient leaves the acute care setting, it is important to help the patient make a safety plan that considers trans-specific issues. These include bringing crucial documents, medication, or other items related to gender transition with them if they decide to leave an abusive relationship and how to locate LGBT-competent survivor support organizations. An example of a comprehensive safety planning tool for trans clients can be found at http://forge-forward.org/wp-content/docs/safety-planning-tool.pdf. It is also crucial for clinicians to assess for suicidal ideation, which is common among trans individuals [39, 40], and may be triggered by an acute experience of assault or abuse.

Clinicians and organizations should develop partnerships with trans-competent community organizations, advocacy services, and providers, so that transgender patients can be smoothly referred to established and trustworthy services for medical and/or psychosocial follow-up. Building professional relationships ahead of time permits clinicians to conduct "warm handoffs" by helping patients connect with services while still in the office, thereby increasing the likelihood of engagement in follow-up care compared to simply providing patients with contact information and sending them home.

Conclusion

The physical exam is an important part of most medical encounters. Principles such as being thoughtful about whether an exam is medically necessary, engaging in shared decision making as to when the exam should be performed, understanding sensitivities that may be more common in LGBT patients, explaining the exam and discussing patient concerns, being open to making modifications to the exam to increase physical and emotional comfort, and being prepared to identify and address distress during the exam can make the physical exam both trauma-informed and LGBT-competent.

Acknowledgments We would like to thank Dr. Maddie Deutsch for editing this chapter and Katja Tetzlaff for creating the illustration. We would also like to thank Dr. Jocelyn Anderson, Dr. Tim Cavanaugh, Dr. Ami Multani, Dr. Henry Ng, Dr. Lori Panther, Dr. Sari Reisner, and Dr. Faiza Yasin for their contributions.

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