

Cultural Competence Case Presentation Intimate Partner Violence in the Gay Community

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Case Scenario/History

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 The patient enters the examination room alone, appearing sullen and withdrawn.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."

a. Review of Symptoms

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.

b. Past Medical History

Environmental allergies. No medications/allergies.

c. Family History

No history of inflammatory bowel disease or cancer

d. Social History

The patient is gay and lives with his older boyfriend of two years. He denies tobacco use, but drinks alcohol heavily each weekend and uses illicit drugs. "I'm not sure what they are really called. My boyfriend gets them for us."

e. Physical Exam

Temp 99.3, **Pulse** 105, **RR** 22, **BP** 125/55, **O₂ Sat** 100% on room air

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

ENT: normocephalic, atraumatic; **PERRL**, **EOMI**, anicteric; moist mucosa

Cardiovascular: tachycardic and regular; **S₁** and **S₂** normal, no murmurs

Lungs: breathing comfortably with good aeration, clear in all fields

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

Rectal: tender 2.5cm perianal laceration at 6:00 position; external sphincter tone intact; a small amount of fresh blood is present; vault empty, prostate non-tender

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 x 4; reflexes 2+ x 4; cerebellar and gait exams normal

Questions for discussion

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

Attitudes/Assumptions: The Physician

This patient is wasting my time. He is lying to me. I know that there is something wrong, but how can I help him if he won't tell me what happened?

I'm not surprised by any of this. He is using street drugs, and he doesn't even know which ones!

I don't have time for something he brought on himself.

I can't believe he is crying. Is this guy for real?

He probably has AIDS too. All gays have HIV.

Attitudes/Assumptions: The Patient

This doctor is laughing at me. He doesn't care and just wants to make a joke out of me because I'm queer.

He's going to judge me. I bet he is a conservative and is going to quote the Bible to me.

I can't tell them that my boyfriend is beating me up. Men don't allow themselves to be beaten.

My boyfriend will kick me out of the house if he finds out about this.

If this doctor calls the police I might get arrested for using crystal meth. The government is really cracking down on meth users.

Provider Knowledge

Knowledge of health beliefs/customs: Relative lack of awareness of intimate partner violence among same-sex couples. Street drugs are less dangerous when not injected.

Knowledge of community: Drug use is often associated with intimate partner violence. Methamphetamine, a highly-addictive 'new' illicit drug, is associated with increased sexual drive and unsafe sexual practices.

Knowledge of disparities/discrimination: Homosexuality has historically been viewed as a 'perversion... against nature.' Homosexual 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 & Skills to Improve Communication

Questions about sexual orientation should be direct and free of judgment

"Do you have sex with men, women, or both?"

Do not ask: "Are you sexually active?"

Such questions place a burden on the patient to disclose their orientation, leading to confusion or embarrassment if the patient simply responds, "yes."

Do not ask: “Are you homosexual?”

Some patients may not identify themselves as ‘gay’, ‘lesbian’, or ‘homosexual’, despite sexual practices with same-sex partners.

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 certain sexual acts. Was anything put in your rectum that could have torn the muscle?”

Details of possible intimate partner violence should similarly be solicited in a direct, yet supportive manner.

“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 tonight?”

3. *What medical issues concern you about this patient?*

- Intimate partner violence
- Substance abuse
- Possible depression and/or suicidal ideation
- Anal laceration

4. *Which of the ACGME core competencies are applicable to this case?*

- a. **Patient care** – cases of intimate partner violence 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
- b. **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, intimate partner violence, and cultural competence with LGBT (lesbian, gay, bisexual, transgender) health issues
- c. **Interpersonal & Communication Skills** – a professional and non-judgmental approach is essential when obtaining a sexual history. 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
- d. **Professionalism** – providers often encourage 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
- e. **Systems-based learning:** this case may require a resident provider to utilize multiple referrals for potential outpatient care (proctology, addiction counselor or program, psychiatrist, STD clinic, shelter). Residents should become familiar with referral systems to such agencies in their communities.

Case Outcome

Diagnoses: Anal laceration; intimate partner violence; substance abuse; depression

Disposition: Discharge with sober friend

The details of the patient's injuries are obtained in a supportive manner. Once comfortable, the patient is pleased to have an understanding healthcare provider show interest in his troubled home life. 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, as well as an appointment in the STD clinic for screening. 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.

References

1. Fry RD. Anorectal trauma and foreign bodies. *Surg Clin North Am.* 1994. 74(6):1491-1505.
2. Halpern CT et al. Prevalence of partner violence in same-sex romantic and sexual relationships in a national sample of adolescents. *J Adolesc Health.* 2004. 35(2):124-132.
3. Halkitis PN, Parsons JT and Stirratt MJ. A double epidemic: crystal methamphetamine drug use in relation to HIV transmission among gay men. *J Homosex.* 2001. 41(2):17-35.
4. Owen SS and Burke TW. An exploration of prevalence of domestic violence in same-sex relationships. *Psychol Rep.* 2004. 95(1):129-132.
5. Paul JP et al. Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents. *Am J Pub Health.* 2002. 92(8):1338-45.
6. Skegg K. Sexual orientation and self-harm in men and women. *Am J Psych.* 2003. 160(3):541-546.