‘There Is No Manly Speculum’: The Gender and Power Dynamics of Cervical Cancer Screening for Transmasculine Patients

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Student Name: Ida Bernstein, BA

Scholarly Report Title: ‘There is no manly speculum’: The Gender and Power Dynamics of Cervical Cancer Screening for Transmasculine Patients

Mentor Name(s) and Affiliations: Jennifer Potter, MD, Director of Women’s Health, Fenway Health; Internal Medicine, Beth Israel Deaconess Center

Abstract

Title: ‘There is no manly speculum’: The Gender and Power Dynamics of Cervical Cancer Screening for Transmasculine Patients

Ida M. Bernstein, Madina Agénor, Sarah Peitzmeier, Dana J. Pardee, Natalie Alizaga, Sari L. Reisner, Michal McDowell, Jennifer Potter

Purpose: Transmasculine people are at risk of cervical cancer, yet have lower rates of cervical cancer screening than cisgender women. The cervical cancer screening encounter represents a site of complex gender and power dynamics, especially given the multiple factors that may compound the vulnerability of the gynecological exam for this population. This study aimed to elucidate mechanisms of gender and power in the gynecological encounter in order to assess how these dynamics may operate to influence patient care experiences and utilization of cervical cancer screening.

Methods: A qualitative, grounded theory approach was used to analyze patient in-depth interviews (n=32), patient online surveys (n=84) and provider focus groups (n=17) that assessed experiences receiving or providing Pap tests to transmasculine individuals, respectively.

Results: Interrelated factors at the institutional, interpersonal and intrapersonal levels affect the relative power the patient and provider possess upon entering the clinical encounter. The position of power each party occupies determines their level of influence over iterative processes through which gender is defined and control is exerted in the visit. Gendering processes included 1) use of patient identifiers, 2) naming of bodies, 3) invocation of gender stereotypes, and 4) representation of gender as biology. Processes that may shift locus of control included 1) consent and compliance, 2) interpersonal discrimination, 3) adherence to norms of professional language, 4) negotiation of transition-related care, 5), breaching the body, 6) objectification, and 7) othering and pathologizing. The interplay of power and gender dynamics in the gynecological encounter ultimately functions to promote or constrain patient agency over body and health. Alignment with the patient is achieved by provider affirmation of self-determined gender, whereas gender disaffirmation places the provider in opposition to the patient and asserts
provider authority over patient agency. Empowering care experiences were associated with enhanced feelings of safety, capacity for self-advocacy and reduction in dysphoria-related distress whereas disempowering interactions induced feelings of violation, severe emotional distress, persistent distrust of providers and decreased utilization of care.

**Conclusion:** The level of gender affirmation and patient empowerment during the gynecological visit has a significant impact on patient experience and subsequent utilization of cervical cancer screening. Understanding the provider role in power and gender dynamics is critical to promoting patient-centered care for transmasculine individuals. Providers can tailor behaviors and the clinical environment to modify gender defining and power exerting processes in the visit to promote patient affirmation and agency.
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I. Introduction

Transmasculine individuals-- people assigned female sex at birth who self-identify as men, male, female-to-male, trans men, trans male or another gender-nonconforming gender identity on a diverse spectrum of masculinity (Reisner, Radix, & Deutsch, 2016)-- engage in a range of sexual behaviors with partners of various sexes and genders and are at risk of human papillomavirus (HPV) and cervical cancer (Kenagy & Hsieh, 2005; Kenagy, 2005; Reisner et al. 2014). Medical professional organizations (ACOG, 2011) recommend that transmasculine individuals follow the same cervical screening guidelines as cisgender women-- people assigned female sex at birth who identify as women. Limited research on cervical cancer prevention among transmasculine individuals has shown that this marginalized community may have significantly lower odds of receiving regular Pap tests compared to cisgender women (Hoskin, Blair, & Jenson, 2016; Johnson et al. 2016a; Peitzmeier et al. 2014).

Few studies have explored the possible sources of these cervical cancer screening disparities. Health care providers may perceive transmasculine individuals to be at low risk of cervical cancer and be less likely to recommend regular screening to their transmasculine patients in comparison to their cisgender patients (Agénor et al., 2016). Rare studies that have assessed patient-sided barriers to either cervical cancer screening or gynecological care generally suggest vulnerability of transmasculine patients during the pelvic exam may be compounded by gender dysphoria (Dutton, Koenig, & Fennie, 2008; Hoskin, Blair, & Jenson, 2016; Johnson et al., 2016b). The important role of gynecologists in ensuring access to transition-related and preventive care for transmasculine individuals has been emphasized (ACOG, 2011; Obedin-Maliver, 2015; Unger, 2014), yet our practical guidelines for cervical cancer screening released previously are the only existing specific recommendations aligned with this goal (Potter et al., 2015).

Power is distributed unequally in the patient-provider relationship; providers possess expert knowledge and control access to therapies patients may require to maintain or regain health (Govender & Penn-Kekana, 2008; Nimmon & Stenfors-Hayes, 2016; Pauley, 2011; Peppin,
Power asymmetries may be reinforced for patients that are part of disadvantaged social groups (Peppin, 1994). Power relations in the clinical encounter are not fixed, but rather continuously constituted and negotiated (Lorentzen, 2008; Nimmon & Stenfors-Hayes, 2016; Pauley, 2011).

Disempowerment undermines patient dignity, sense of self and personal effectiveness, whereas active involvement in health decision-making and empowerment improves health outcomes (Goodyear-Smith & Buetow, 2001; Nimmon & Stenfors-Hayes, 2016; Peppin, 1994). The single study exploring physicians’ conceptions of power and relevant intentionality in the encounter found that those who maintain awareness of power dynamics use deliberate communication strategies to manage their position of power with integrity (Nimmon & Stenfors-Hayes, 2016).

The gynecological exam is widely acknowledged as an invasive experience of heightened vulnerability and loss of control in which the patient is put in a position of “subordination,” both figuratively and physically (ACOG, 1979; Areskog-Wijma, 1987; Hilden et al. 2003; Moore et al. 2000; Oscarsson, Wijma, & Benzein, 2008). The cisgender patient experience with the exam has been associated with fear, humiliation, shame, degradation, anxiety, passiveness, helplessness, dehumanization, pain, violation, and feeling threatened (Areskog-Wijma, 1987; Hilden et al. 2003; Hoskin et al. 2016; Moore et al. 2000; Oscarsson & Benzein, 2002; Oscarsson et al. 2008; Weiss & Meadow, 1979; Wijma & Siwe, 2004). These experiences have sometimes been linked with internalized sexism regarding the shamefulness of “female” genitalia (Hilden et al. 2003; Hoskin et al. 2016; Weiss & Meadow, 1979). Preferences for patient-provider communication, including personalization, evidence of genuine care, being informed and “treated as equals,” and the important role of a trusting clinical relationship have been consistently emphasized (Armstrong, James, & Dixon-Woods, 2012; Moore et al. 2000). Notably, studies have only rarely framed the patient-provider interaction in explicit terms of power relations (Cook & Brunton, 2015; Larsen et al. 1997; Wijma & Siwe, 2004).

The literature has highlighted unique factors that may affect the power dynamics involved in the general care of transgender patients, including an unavoidable dependency on the medical system for “basic identity expression” for those individuals who seek transition-related care (Spade, 2003; Stroumsa, 2014; von Vogelsang et al., 2016). The transgender community also
faces profound structural, interpersonal and individual stigma in all areas of life, including healthcare (Bauer et al., 2009; Cruz, 2014; Grant et al., 2011; Kosenko et al. 2013; Lambda Legal, 2010; Ross & Castle Bell, 2017; Stroumsa, 2014; White Hughto, Reisner, & Pachankis, 2015). Interpersonal stigma functions to reinforce the power and authority of providers in medical encounters with transgender patients (Poteat, German, & Kerrigan, 2013). Though the pervasiveness of stigma in clinical settings has been well-documented, only a handful of studies have detailed specific provider behaviors that patients perceive as stigmatizing (Kosenko et al. 2013). Provider behaviors that have been identified include displays of discomfort, denial of services, verbal or physical abuse, and coerced or substandard care (Bauer et al. 2009; Kosenko et al. 2013; Lambda Legal, 2010; von Vogelsang et al., 2016). Bauer et al. (2009) identified “cisnormativity,” as underlying the processes of systematic erasure of transgender individual in healthcare contexts. Cisnormativity describes the ubiquitous expectation “that all people are cissexual, that those assigned male at birth always grow up to be men and those assigned female at birth always grow up to be women” (Bauer et al. 2009). Cisnormativity in sex-segregated systems negates the existence of transgender people.

“Gender affirmation” is a multidimensional social process by which an individual is recognized and affirmed in their gender identity, expression, and/or role (Reisner et al. 2016). Lack of gender affirmation negatively impacts health care utilization, including preventive health screenings (Reisner et al. 2016). Gender affirming care involves holistic attention to the physical, mental, and social health needs and well-being of transgender individuals while respectfully affirming gender identity (Reisner et al., 2016). The correct use of a patient’s chosen name and pronouns is key to gender affirming care (Kosenko et al. 2013; Redfern & Sinclair, 2014; Reisner et al. 2016; von Vogelsang et al. 2016). One study identified gendered language in conversation with transgender patients and cisnormative medical forms as an important mechanism of gender (dis)affirmation; otherwise, information on potential gendering processes in the clinical encounter is also sparse.

For members of the transmasculine community, the cervical cancer screening encounter represents a site of complex gender and power dynamics, especially given the multiple factors that may compound the vulnerability of the gynecological exam for this population. This
qualitative study, as part of a larger research project examining the cervical cancer screening experiences of transmasculine individuals, aimed to elucidate mechanisms of gender and power in the gynecological encounter in order to assess how these dynamics may operate to influence patient care experiences and utilization of cervical cancer screening.

II. Student Role

Study Logistics
During an Academic Research Year/Fifth Year in 2013-2014, I served as study coordinator and was responsible for managing IRB applications, the study budget, grant applications and coordinating activities of the research team, including monthly meetings.

Study Design
I led the design of the patient online survey as well as provider focus group guide. Collaborator S.P. led the design of the patient in-depth interview guide.

Participant Recruitment
S.P. led the recruitment of participants for the patient in-depth interviews. I led the recruitment of the provider participants and assisted in disseminating the patient online survey.

Data Collection
I led the provider focus groups and interviews and managed the patient online survey. S.P. interviewed the patient in-person participants.

Data Analysis
N.A., M.M. and myself assisted in the transcription of patient and provider audio recordings, formulated the patient codebook and completed focused coding of the patient interview transcripts with guidance from M.A. and S.P. In addition, I coded the survey responses, developed the provider codebook and coded the provider focus group and interview transcripts. I developed the code categories, axial codes and themes pertaining to the theory presented herein
which were reviewed with the research team and revised accordingly. I drafted the entirety of this manuscript with review and edits from J.P.

III. Methods

Setting
This mixed-methods study was conducted at Fenway Health, a Federally Qualified Health Center and research facility in Boston, MA that specializes in the primary care of sexual orientation and gender identity minority individuals (Reisner et al. 2015). In 2013, patients completed either an in-person, semi-structured in-depth interview (n=32) or an online survey (n=84); no individual completed both. Focus groups (n = 3) with healthcare providers (n=15) were conducted as well as two in-depth interviews with providers who could not attend the focus groups. This study was approved by the Fenway Health Institutional Review Board.

Patients: Data Collection and Analysis

In-depth Interviews
We used purposive sampling (Patton, 2002) to select individuals who were assigned a female sex at birth, self-identified along the transmasculine spectrum, had a cervix, and were 21-64 years-old (per US cervical cancer screening guidelines) while maximizing diversity in age, race, and time of last Pap test (Saslow et al. 2012). We recruited patients through Fenway Health, local community-based organizations serving transgender individuals, social media, and the 2013 Boston Pride festival (Arcury & Quandt, 1999). Data collection ended after 32 interviews due to achievement of purposive sampling goals and thematic saturation.

The semi-structured guide was reviewed by experts in qualitative research, transgender health and cervical cancer, and addressed transmasculine individuals’ perceptions of HPV and cervical cancer risk and prevention, experiences obtaining a Pap test, interactions with healthcare providers, access to health information, and gender identity in the context of cervical cancer screening (Appendix A). After obtaining written informed consent, S.P., a cisgender woman, conducted the patient in-depth interviews in a private room at Fenway Health. S.P. had
experience working with transgender populations and checked in regularly with transgender team members for guidance and advice. The interviews were conducted in English, audio-recorded and lasted between 60 and 125 minutes. At the end of each interview, participants completed an anonymous questionnaire regarding their sociodemographic characteristics. Participants received US$50 for their participation.

We transcribed the interview audio-recordings verbatim and entered the transcripts into ATLAS.ti (2015, version 7). Data analysis was guided by the principles of grounded theory (Charmaz, 2006; Corbin & Strauss, 2008; Creswell, 2007). The patient interview transcripts were coded using a line-by-line and then focused coding approach using a codebook comprised of inductive codes. Coders met several times to discuss their coding decisions, reconcile discrepancies, and revise the codebook. The coders and other members of the research team then developed categories based on multiple codes using axial coding and formulated themes comprised of multiple categories, which was facilitated by writing memos and discussions with other research team members. These themes were then abstracted into the framework presented here, which emphasizes the underlying processes linking themes together (Charmaz, 2006).

Online survey
Following the completion of the patient interviews, an online survey was administered in an attempt to sample individuals who did not feel comfortable discussing cervical cancer screening in-person and whose care experiences may have differed significantly from the interviewed participants. Online survey participants were eligible to participate if they identified on the transmasculine spectrum and were 21-64 years old. There were no restrictions regarding geography or cervix retention. Individuals were recruited as above.

The online survey was adapted from the in-patient interview guide and included both closed- and open-ended questions (Appendix B). Participants were able to skip any question. An informed consent waiver was obtained for all survey participants. No direct interaction between study staff and survey participants occurred; no incentive was provided.

Following analysis of the patient in-depth interview data, open-ended question responses from
online survey respondents were read for additional or disconfirming themes. Data saturation was confirmed, and no codes necessitated revision. Analysis proceeded as above.

**Healthcare Providers: Data Collection and Analysis**

Eligible healthcare providers needed to hold an advanced nursing or medical degree and to have performed at least one Pap test on a transmasculine individual. We used maximum variation sampling to help ensure the inclusion of providers from various professional backgrounds and settings (Marshall, 1996; Patton, 2002). We recruited healthcare providers at Fenway Health, through referrals from patient and provider participants and by consulting local World Professional Association for Transgender Health listings.

The provider guide focused on clinicians’ perceptions of HPV and cervical cancer risk and prevention among transmasculine individuals, as well as their experiences and recommendations for providing Pap tests to transmasculine patients (Appendix C). After obtaining written informed consent, I.M.B. and S.P. conducted the healthcare provider focus groups and in-depth interviews in a private room at Fenway Health or Beth Israel Deaconess Medical Center. The interviews and focus groups were conducted in English, audio-recorded and lasted between 60 minutes. Provider participants were served a meal during the focus groups.

We transcribed the interview and focus-group audio-recordings verbatim and entered the transcripts into ATLAS.ti (2015, version 7). The provider transcripts were coded using a codebook of deductive codes, which was based on the provider focus-group guide and developed in consultation with other members of the research team (Charmaz, 2006; Corbin & Strauss, 2008; Creswell, 2007). Analysis proceeded as above.

**IV. Results**

**Sociodemographic characteristics of patient and provider samples**

Sociodemographic characteristics of patient interview (n=32) and online survey (n=84) participants are presented in Table 1. Interview participants had a mean age of 33, 77% were
white, median income bracket was $10,000 to $20,000, and the median education level was college graduate. Survey participants had a mean age of 32, and 94% were white (other sociodemographic characteristics not collected). Among the provider participants, 77% were cisgender women and 65% were physicians (Table 2). 59% of provider participants practiced at Fenway Health and 29% of providers practiced in a hospital setting.

Qualitative Findings

*Interplay of power and gender dynamics - the theory*

We have identified conditions in and processes by which power and gender are constructed in the gynecological encounter with transmasculine individuals. Ultimately, the interplay of power and gender dynamics functions to promote or constrain patient agency over body and health (Figure 1). Interrelated factors at the institutional, interpersonal and intrapersonal levels affect the relative power the patient and provider possess upon entering the clinical encounter. During the patient-provider interaction, the position of power each party occupies determines their level of influence over iterative processes through which control is exerted and gender is defined in the visit. Alignment with the patient is achieved by provider affirmation of self-determined gender, whereas gender disaffirmation places the provider in opposition to the patient and asserts provider authority over patient agency. Thus, gender-affirming interactions bolster patient empowerment while gender disaffirming interactions act to disempower transmasculine patients who access this critical medical care.

I think seeing your patient as male and reassuring them that like, ‘Dude it's okay, you're still a dude and you're doing this thing that's important for your body,’ I think that can make all the difference in the world. I think more medical professionals need to have that kind of training. I think it's one thing to treat a trans patient, and I think it's quite another to constantly validate and reassure them that you're on their side, you know? (Male, 26, interview participant)

Each portion of Figure 1 will be described in detail below, using illustrative quotations from study participants. Each patient quotation is followed by the participant’s self-identified gender identity, age and source (i.e. interview or survey participant). Each provider quotation is identified by the participant’s gender identity and professional discipline.
Multilevel forces shape patient empowerment and resilience at the onset of the clinical encounter

Multilevel factors:

Experience of intersecting oppression and privilege

Nearly all participants described experiences of institutional marginalization and interpersonal discrimination due to their gender identity-

It's either just like things throughout my day that I'm like a lot more aware of with my gender identity because I'm transitioning, than a cisguy would ever be. Um, like cisguys don't worry about going to use the restroom…I am constantly on the lookout, um, for finding single stall restrooms. Um, but it's just like, finding restrooms, worrying about health care providers, worrying about talking with insurance companies for health insurance. Um, worrying about, I guess, just general harassment…People don't know you but you might look a little bit different to them, so they might yell something. And that was something that I think I am more, uh, attune to, just because of being from the South and for like, having people verbally harass me often enough that [I’m] like, on edge from it. (Transman/trans guy/trans*, 24, interview participant)

Health care settings in general were potentially fraught for all transmasculine individuals, due to systematic erasure by medical institutions and past experiences of discrimination by medical providers and staff -

I think it’s not even the procedure but it’s the thought process that comes with it, and realizing that, um, how the system of healthcare really has, in some ways, it’s not setup to help trans people. And so knowing that, like, I can’t change my legal sex, because I still need to get Paps…and that’s the only reason that I can’t do it is that it’s tied to my healthcare. And so, um, I think it’s those thought processes that actually make getting Paps harder, because it again reinforces how there’s kind of institutional discrimination that happens against trans people and how we’re not visible and how we’re not seen.

(Genderqueer FtM, 25, interview participant)

In fact, several participants who had changed their insurance gender marker to male had been denied coverage of cervical cancer screening due to “gender incongruence,” an explicit institutionalized denial of the existence of nonnormative configurations of body and gender.
For any given individual, vulnerability in health care settings was compounded according to the other marginalized and privileged identities held by each individual.

I feel like you’re dealing with folks who have some pretty serious triggers around healthcare and their bodies, already having to be kind of diagnosed as dysphoric or having a disorder, right? So you know, I feel like it’s not an easy thing to do already. I feel like the doctor’s is awkward in general, and then when you like add on kind of a layer of like, you know, gender identity and the complexity around that and then if you add on a layer of ability and class, and you know, you keep adding on those layers then eventually you are dealing with a community that is needing a lot more care- heart care, right? Like in terms of like people being more understanding about their experiences. (Queer/transmasculine, 29, interview participant)

One participant detailed how his own experience of being transgender and living with a disability led to disempowerment in medical interactions -

Being someone born with a physical disability and having a really negative experience regarding my upbringing around that stuff, it's hard in general for me to see a doctor because the medical model of disability is it's own really problematic thing. And when you have people who like want to cure you or fix you or tell you that there's something wrong with you because you're physically disabled on top of being trans, which is seen by and large as something that's quote-unquote wrong with you, it's like I'm two for two. (Male, 26, interview participant)

However, several other participants in our majority white and college-educated sample perceived that privileged parts of their identities granted them greater agency in health care settings, particularly by being “believed” more about their experiences in comparison to transmasculine people of color when accessing transition-related care. One male-identified 24-year-old interview participant who had graduated from college explained-

I've had a very interesting experience as a trans guy, which I feel like I have a very specific privilege with doctors… Like, you know, when you're a patient and just like, you know what you want, you know who you are, and you're like, professionally successful, doctors tend to give you a little bit more respect than I think is deserved for…most of these doctors who come to interact with me as I transition, they tend to just kind of like,
be like, ‘Oh, okay, you want to do surgery? I trust you, you know what you're doing,’ versus like, is there another person that you say, ‘I don't think it's a good idea for you to do surgery’? It makes me a little bit nervous for the people who don't feel the same way, I don't want them to be like, in a place where just like, their authority over self is diminished because their life is, you know, they haven' gotten things together the same way.

Interpersonal factors:

*History of interpersonal trauma*

Several participants acknowledged the high rates of gender-based interpersonal trauma in the transgender community and the associated potential for increased vulnerability in medical interactions.

I know a lot of trans people have had histories of abuse, probably just because of the more of a minority you are, people think you’re crazy. Sadly enough, that happens.

(Transmasculine, 23, interview participant)

Participants with their histories of trauma often experienced a heightened sense of loss of control or even PTSD-related symptoms during physical exams generally, and the pelvic exam specifically. A 27-year-old male-identified interview participant who has never received a Pap test explained his reticence to undergo pelvic exams -

I have a history of being abused, so I really like when people ask me every step if it’s okay and not just go barreling on assuming that like, you know, I’m going to strip down and put this like, stupid little gown on, and you know, just let you go from there…[I have] anxiety about somebody, um, I guess touching me physically, and having difficulty with the idea of, you know, telling somebody, ‘hey hold up, stop this a second,’ or you know, ‘hey, fuck off we need to stop this.’

Some participants disclosed their personal experiences of trauma. Vivid accounts of medical trauma were particularly salient, and these individuals tended to feel persistently unsafe in medical settings thereafter. One participant described his first cervical cancer screening experience, prior to which his provider gave only the limited explanation that he would be taking an internal sample from the cervix and they might undergo “some discomfort” -
Before the Pap smear, I'd never had any vaginal sex. Which means when they put in the speculum they broke my hymen. And it was just utter like, pain for like- I don't even know, I wanna say it was five minutes, probably much shorter than that. But it was just like horrible, horrible, horrible. And afterwards, like I went home and I bled for like two days after that. And then I started to get this weird yellow discharge, so I got an infection after it because they had like ripped the side, I guess. It was really bad. And I was kinda mad. I was like, I didn't wanna do that...And basically the whole time I was like- ‘it hurts a lot.’ And he was like- ‘hang on one second.’ Yeah. And actually they didn't tell me that I was bleeding. Um, it wasn't until I got home and I found that my underwear was covered in blood that I found out...[now] every time that I have any kind of pelvic exam, it's really, really painful. Um, it's probably a combination of like it's painful and what happened the first time makes me really like tense...the first one I felt like I had to. I felt like it was absolutely required or he wouldn't give me testosterone. Um, and I have testosterone now. So there's not a huge incentive for me 'cause I thought I wasn't gonna get T so it's like- I'm just gonna do whatever this guy tells me to. (Trans Male, 22, interview participant)

Interpersonal affirmation

Individuals received varying levels of support and affirmation of their gender identity by both loved ones as well as in general day-to-day interactions with the public; these were often tied to realizing physical transition goals. Participants described the burdens of having to continuously “reassert” their gender identity if they were not consistently read as male by others (Genderqueer (if forced to choose), 27, interview participant). The general level of external gender affirmation one experienced could translate to capacity for resilience in health care settings. Some participants with passing privilege, the ability to be consistently perceived by others as cismale, subsequently felt less susceptible to challenges to their gender identity while receiving medical care. A 23-year-old transmasculine-identified interview participant found Pap tests less distressing as their gender identity became more readily recognized by others -

So its like, even becoming less and less of an issue simply because I’m like, doing my thing and I’m happier. And I’m like, out with my new identity, like I have my name. That’s the way it is. My new job doesn’t know that I didn’t have a prior name, and not that I care so much, but they know me as who I am right now. And that’s like a really
wonderful feeling, so I don’t have that sort of day-to-day like, barrage of questioning I suppose really anymore. That phase has kind of past. Yeah, it makes all those types of things always more easier to manage. So for me, a lot of things tend to mental stress. I usually have to calm the brain; the body doesn’t really care so much.

In contrast, several participants who did not have support from their loved ones experienced more internal strife living in alignment with their gender identity. Some individuals struggled more in healthcare settings where their body, a source of ongoing conflict, was the focus -

I know a lot of people struggle with healthcare providers and feeling empowered and not. You know, I know that's a common thing for many people. But, I would think otherwise that I would feel more entitled and more empowered based on other interactions that I have in life. But, I don't feel that way around healthcare. I don't feel confident and I do feel a degree of shame…and I feel like I'm presenting this source of that shame to the provider to, you know, examine and judge...this sounds so cliché, but like it goes back to like my mother's perception of there being something, you know, grotesque or sinful or all of the above about me…You know, I think, um, that's the stuff that making the decision to transition I had to really move beyond and manage. I think it's pretty absent almost exclusively except in a healthcare setting. Yeah. And you know, logically, I understand all this. I can stand back and analyze myself even. But it's probably the most overwhelming emotional experience that I have at this stage of my life. (Male, 38, interview participant)

Many participants described periods of time during which they did not have the freedom to seek desired physical transition, a source of self-empowerment for many individuals, due to fear of losing necessary supports. For example, one 27-year-old male-identified interview participant could not pursue hormone therapy or otherwise let his parents with whom he must live know that he was “actually practicing” his gender.

Intrapersonal factors:

Self-affirmation

Transmasculine participants described varying levels of self-affirmation, or an internal sense of validation of gendered self and self-actualization (Reisner et al., 2016). Some participants were
more impervious than others in the face of mistreatment or challenges to their self-concept of
gender. Participants often linked their capacity to externalize rather than internalize
discrimination or gender disaffirming interactions to their personal security in their gender
identity -

I think it comes from knowing that even if something does happen, that feels unsafe or weird or whatever, that like, you know, it doesn't change who I am. You know, that this one person treated me in this way, right? Uh, I have friends, I have family, and at this point, I've been out long enough that I have some sense of security too of like, just in who I am. That one person, even if it's a really bad experience, is not going to change these, like, fundamental things about me. Like, they don't know me. (Male, 27, interview participant)

For many, actualization of transition goals facilitated self-affirmation and self-empowerment -
I know for me earlier in transition, you know, before I started T, before I changed my name, I was a lot less confident in who I was and a lot more guarded as far as, you know, how I interacted with people. But, you know, after starting T, and my body looking more like how I wanted to look and you know, for my name to be how I wanted to be…the further along I've come, the more confidence I've had, the more I'm able to speak out, and just be like ‘Look, you're pissing me off. You're wrong. This is how I need you to talk to me. This is how I need you to interact with me. If you can't respect that, I can't respect you.’ That's all I'm asking, just some respect. (Male, FTM, 21, interview participant)

While security in a transmasculine participant’s self-determined gender was frequently related to progression in their transition, it was not necessarily related to the level of body-related dysphoria experienced by that individual. For example, a 38-year-old male-identified interview participant expressed considerable discomfort with his genitals and the experience of cervical cancer screening, but has become more readily able to cope with reminders of his gender assigned at birth -
I feel more confident in my manhood, you know? And it really doesn't occur to me day in and day out- most of the time I'm just a guy… So that when I do have to open the drawer, it's just, um, I know I can close it again. For a long time, I was really haunted by the
sense of like, on some level I believed that it would all switch back. You know, like something would happen and all of the sudden everything would be like it used to be. And, like I sort of stopped having that nagging fear…I mean I think it's been a progression, but I think that it was probably two or three years ago that it really occurred to me that I had cut across the line, and I kinda left that nagging fear behind me.

Health literacy

The majority of participants exhibited limited understanding about Pap tests. Several provider participants confirmed this about many of their patients, both transmasculine and cisfemale alike. In the absence of gynecological health knowledge, patients tended to blindly follow provider recommendations rather than making informed decisions about their individual care. Others were simply unmotivated to seek preventive gynecological care.

I don’t know actually anything really, about any of that stuff. I mean, I know that I do it, but I actually have no idea what’s going on inside by body…If they tell me I have to do it, I just do it. (Trans/queer, 35, interview participant)

Some patients that underwent Pap tests with little knowledge of the process and/or had difficulty communicating with their providers experienced heightened anxiety and sense of loss of control during the exam. One 29-year-old queer/transmasculine-identified interview participant attributed his limited knowledge about Paps to his lack of access to health information coming from a “low-income background.” He described his first experience ever receiving a Pap -

The thing is like they don’t explain any of the tools, right, so I didn’t know what was going on down there. All I know is that I had these stirrups on. It was uncomfortable. I assume that they were opening me up with a clamp um, because I saw the clamp. And then they inserted something that was extremely painful, and I didn’t know what that was. And so that, for me, was really off putting, because I’m like, I don’t even know what you’re putting in my body, like I don’t even know what the step-by-step process is. I’m process-oriented so I need to know what is happening. Like what are these tools? What is a possible sensation that I might feel? Is it supposed to be this painful? It was just pretty much like ‘alright, let’s go!’
Those participants with increased understanding of their health needs and fluency in medical language, often related to employment in a medical or technical field, had greater ownership over their care experience. A 34-year-old male-identified interview participant employed in medical research, explained facilitators of his active participation in informed decision-making and self-advocacy -

I'm quite understanding, have the knowledge, have a background, um, therefore I think that I can say um, to my provider, ‘Look, I understand the risks, um, I know about this test. I find it very uncomfortable…I find it's hard to discuss with you. Um, so therefore uh, I know that I have to have this done, so when you conduct it, can you please you know, not mention uh, the cervix and just do it as swiftly as possible?’ I think I could do that. Um, I don't know if other people could, you know…you need to speak to your physician 'cause you're not gonna get the requirements you need or the support you need on your health if you don't discuss to them.

Multilevel factors determine provider authority at the onset of the encounter

Institutional factors:

Role as impartial arbiter of science

The expected role of a neutral proxy for science is the source of provider authority to access patients’ bodies during the physical exam. Patient participants ultimately allowed medical providers to see and touch their body because they believed a provider’s motivation for doing so would be purely medical, uncharged and nonjudgmental.

Now if it was someone who wasn’t a medical professional, I’d probably feel worse about it, just because, I don’t know, I guess because the medical professional is trained to look at the human body as the human body…a normal person looks at someone’s body and they go, you know, ‘Oh, that’s that so-and-so person, they’re like this. And oh, they’re a little strange aren’t they?’ And they think, and they twist around, and, you know, it’s a social thing. But with a doctor, it’s like, ‘This is the human body. This is what it needs to do, and this is how you need to be healthy.’ And I understand that, because that’s their profession, it’s what they’re trained to do. (Male/Transmale, 23, interview participant)

Providers earn the status and mystique of arbiters of science through acquisition of knowledge and truth about bodies that is not readily accessible to the public.
You see this guy with a white coat and a stethoscope who has gone to school for like 8,000 years, and you know, doctors are the boss. They’re the epitome of the educational, you know, elite. It is very hard for people to say to a doctor ‘hey wait, this isn’t how you should be doing this, this isn’t comfortable for me. Are you sure about this?’ Um, you know, ‘Can I refuse this test?’ and I think sometimes it’s very hard for doctors to accept that too. Um, and it’s even harder when it’s something that you’re desperately uncomfortable with. (Male, 27, interview participant)

From these conditions is born the assumption that providers “know better” and that patients should defer to their recommendations in lieu of shared decision-making (Genderqueer (if forced to choose), 31, interview participant). Furthermore, provider monopoly on health knowledge grants them the authority to delineate what is normal versus abnormal or pathological.

Transmasculine participants described ways in which providers also defined norms around transmasculine identity. These norms were often couched in terms of a rigid gender binary or stereotypes about the salience of medical transition and body parts to the transgender experience, an erasure of the diversity of experience among the transmasculine community both represented by and acknowledged by our transmasculine participants -

In any health setting, you're serving such a diversity of people. Um, I guess where it gets difficult for me is when one talks about the trans spectrum, especially with female to male. You know, it's like a lot of people make an assumption about what it means to transition, and I don't think that applies very well to a lot of female to male trans. You know, it's like a lot of people revolves around the penis. And that may or may not be the case, especially for you know, guys like me. (Male, 38, interview participant)

Providers’ determinations of what constitutes transmasculine identity take on particular weight in their role as gatekeepers of transition-related care (see below). The act of defining the community in strictly clinical terms renders transmasculine identity pathological. When asked what advice she had for providers without experience caring for transmasculine patients, a cisfemale Family Medicine physician, explained -

I think I would tell my colleagues to try to see it as a medical problem, because that's what it is. It's not a lifestyle choice. It's not a sexual orientation. It's not a fetish.
This provider perceived that once her colleagues understood difference as a medical issue, they would be able to accept that an intervention, i.e. transition-related care, is warranted. In contrast, several patient participants resisted the idea that their gender identity was a medical issue, or that it was inextricably linked to medical and/or surgical interventions.

Role as gatekeeper of transition-related care
As gatekeepers of transition-related care, medical providers have the power to regulate transmasculine bodies in accordance with their medicalized conception of transgender identity. A provider’s determination that a patient can proceed with medical transition thus becomes a form of validation of gender identity that may have undue influence over a transmasculine individual’s capacity to self-determine how best to align their physical and social selves with their gender identity.

She did the typical psychiatric evaluation or whatever it is to stamp me or not to stamp me with gender identity disorder. And I don't like labels, but I wanted that label because that would mean that I really am. (Male, 56, interview participant)

The gatekeeping role also intensifies the imbalance of power in the transmasculine patient-provider relationship -

I think being um, the hormone and the primary care provider, I have a little bit more like, capital to spend with patients because I kind of control - as messed up as the power dynamic is - I sort of like control their hormone prescription, and so I think people are more willing to come back and see me than if I were just like some random GYN person who was saying, ‘You should do this.’ (Cisfemale, Primary Care, Nurse Practitioner)

This provider perceived a consequence of this power imbalance, the greater likelihood of patient follow-up with transition care providers, as beneficial. However, the potential for undermining patient agency and distorting the patient-provider relationship when a provider exercises their authority as gatekeeper cannot be overstated.

And when I told him I worked at Fenway, he said, 'Oh yeah, you know, I'm happy to do breast implants for transwomen. I love that population; they're really appreciative, they're easy to deal with, they're not obsessing about a quarter inch here and a quarter inch there. And I had a transgender woman come in and, uh, she let me see her vagina.' And I'm
thinking, oh my god! She comes in for a breast augmentation and you look at her vagina? How inappropriate is that? (Cisfemale, Family Medicine, Physician)

_Scarcity of care for transmasculine individuals_

Many participants reported a deficiency of available medical providers who would care for transmasculine patients generally, and who would provide transition-related care especially. Among available providers, those who had basic knowledge in transgender health and/or were culturally competent were an even greater minority. The burden of trying to find safe providers was considerable, particularly if a transmasculine individual did not have ready access to word-of-mouth referrals from other community members. Several participants described accepting suboptimal care or tolerating mistreatment from a provider due to the perception they could not get care elsewhere. Others simply avoided care completely.

There's very much like a scarcity mentality with trans doctors…Sometimes you're just like happy that someone's continuing your 'script, you don't um, push for all this extra holistic stuff, and you just are like, I'm happy that I even have someone who can continue to do this, because um, I have no control in this, um, if I can't see this person, I just don't get it…there's all these people who want these very few doctors who are willing to prescribe testosterone, so you just are like, okay, I take my short little time, and then that's what it is…I'd really love uh, like a doctor that maybe we felt like we had a better relationship. Um, but I feel limited. (Genderqueer (if forced to choose), 31, interview participant)

Transmasculine participants reported that providers often cited inexperience with transgender health when they were turned away from care. However, ignorance of transgender health was perceived by some to be willful and unjust, rather than a true lack of skill or ability. For example, resistance to exposure to vulnerability on the part of providers may perpetuate the scarcity of care for transmasculine individuals -

We are people and we have very specific health care needs that really in the grand scheme of things, they're not really special accommodations or anything. Like I've had all kinds of instances, like, ‘Oh, well we're not skilled with trans people.’ It's like, really? I'm here for a checkup. Or I need a flu shot. So what's the problem? (Male, 26, interview participant)
A 21-year-old interview participant who identifies as FtM fluid also noted that provider inexperience was rooted in a lack of prioritization or will to seek education in transgender health:

I feel like part of being in the healthcare, um, field is constantly educating and re-educating yourself as, you know, new things come up, um, because, you know, healthcare is constantly morphing, we haven't found the cure for everything yet…it doesn't seem like GLBT issues or trans issues, specifically, are you know, part of that ‘keeping yourself educated’ thing, um, so that's kinda- it's frustrating.

Interpersonal factors:

Support from colleagues

Insofar as feeling uncertain in a clinical encounter threatens the authority of a provider as a scientific expert, factors that increase provider comfort or confidence caring for transmasculine individuals work to preserve that authority. Several provider participants cited advising from colleagues and mentors who were more experienced in transgender health as an important source of support, particularly when first becoming involved in this care. A cisfemale nurse practitioner in a primary care practice specializing in care for LGBT youth explained how she coped with her initial “terrifying” experiences providing Pap tests for transmasculine patients -

I had really good, um, my supervising physician and my other colleagues…I could just ask questions any time, and you didn't feel alone because other providers who were awesome and had been doing this for a long time had similar experiences to you, so you didn't feel stupid or like, ugh, you know, beat yourself up about certain things, and so I just had a really supportive group of providers and if I didn't, I think that would have been really hard.

Intrapersonal:

Level of comfort caring for transgender individuals

Provider authority is partially based in their claim on expert scientific knowledge; however, providers face various barriers to gaining expertise and comfort in the field of transgender health. The lack of basic knowledge in transgender health due to the widespread exclusion of transgender health topics from medical education and training was noted by many transmasculine participants noted and acknowledged by at least one provider -
I wasn't taught in medical school anything other than, 'Some people are transgender.' And so, you don't know what you're looking for, you don't know what people are feeling, what their background is, how to talk to them. (Cisfemale, Family Medicine, Physician)

Knowledge in transgender care then necessarily came from the patient, a reversal of the usual directionality of knowledge transfer in the clinical visit. Patient assertiveness in the context of provider ignorance could be received as an unconventional challenge to provider authority. This physician went on to explain her experience of this role reversal -

What we know about trans health comes from the patients - not from the literature and not from studies. So the patients have come to their physicians with all of the information, and you have to respect that. And when you see a patient, they may be very defensive and might seem overly assertive, but it comes from having to do that in order to get their medical needs met...And, um, you know, once you get that piece then you can quickly help the patient to relax and let down their guard, and a lot of the off-putting affect goes away.

The gender binary and conflation of gender and normative biological sex is systematically reinforced in medical training and practice. Many transmasculine participants perceived this was a major source of provider discomfort with transgender patients.

I think probably for many doctors there is this kind of like, ‘This person has a male name and they have female plumbing, and I don’t know what to do with this information.’ I suspect that you know [OB/GYN] training is like, ‘You’re going to be seeing women. You’re going to be seeing women in a women’s practice,’ and you know, ‘women, women, women’ and you know, then there are trans people who are male who need you know, pelvic care or OB/GYN care, and I think there is a disconnect where they just don’t quite know what to do with that. Um you know, it’s like, it’s like if you go to an office, a doctor’s office, and like, the brochures for women have like pale pastel daffodils on them and they’re in like purple and pink, and then there’s like the men’s which are in bold shapes and geometric colors and things like that, and OBGYNs sort of go into their practice expecting like pastel daffodils, and that’s not what they get. (Male, 27, interview participant)
A few provider participants also noted the challenge of reconceptualizing gender while normative gender cues were present in every aspect of the clinical environment. A cisfemale OB/GYN resident, recounted her first experience administering a Pap test to a transmasculine patient -

As the provider sometimes, especially when I'm running, I feel like I might be more nervous than the patient, because I don't want to make the patient feel uncomfortable, um, and so, you know, the whole time I kept saying to myself, I have to remember to say 'he' and 'he,' even though all over the chart it says 'she,' 'she,' 'female,' 'female' you know, and so, it's just, you know, I was just trying not to slip.

Provider participants who worked in clinics specializing in LGBT care were more readily able to challenge assumptions around gender and biology ingrained during their medical training than providers who worked in other settings. The latter group of providers outright rejected the possibility of mentally reframing the Pap test as a gender neutral experience -

I don't even think I understand what that means to make it more male-friendly.
(Cisfemale, OB/GYN, Resident)

There’s no manly speculum. It just doesn't - incongruent. (Cisfemale, OB/GYN, Physician)

There’s no way. (Cismale, Reproductive Endocrinology, Physician)

In fact, men who come for anal Pap smear, I say like, ‘Oh, it's just like women getting Pap smears, you know, 1 to 3 years, you have to do it for men who have sex with men.’
(Cisfemale, Infectious Disease, Physician)

Many provider participants also experienced feelings of anxiety, discomfort and even terror when caring for transmasculine patients due to the fear of harming an already vulnerable patient population, which may also work to attenuate provider confidence and sense of authority -

They've been through so much hell, I mean just to be who they are in the world, and then you don't wanna give them more hell, you know, so it's like, they've been through so much prejudice and maybe trauma, and just getting through the day trying to be themselves and be seen as who they want to be seen as, and then, to have just one more layer of something uncomfortable - you just don't ever want to hurt anybody here, you
know. Poor people come in here, crawl in this place, you don't wanna do one more thing to make their day bad. (Cisfemale, Primary Care, Physician Assistant)

Provider participants, particularly those with less experience, had concerns about using the wrong terminology or otherwise offending patients, causing pain and becoming “another person in their long list of providers that they've had bad experiences with.” (Cisfemale, Primary Care, Nurse Practitioner)

Many provider participants in our sample had significant experience providing gynecological care for transmasculine patients and overcame these barriers by pursuing extensive self-education through conferences, professional guidelines, trainings, scientific literature and lay media. Several of the more experienced participants expressed a high degree of confidence in their cultural sensitivity and understanding of transgender health. Some of these participants tended to assert their “expertise” in the clinical encounter by making broad generalizations about the experience and needs of transmasculine individuals.

The first thing I do is acknowledge that they really don't want to have this done, but that it is a necessary part of care. So the first thing I do is acknowledge their discomfort…before, um, any undressing we discuss the fact that this is not going to be a good experience- will be successful hopefully, but not a gratifying experience. (Cisfemale, Gynecology Practice, Nurse Practitioner)

At times, these statements were in direct conflict to the express wishes of transmasculine participants -

She assumed immediately that I didn't wanna do it because I was trans. Well she basically said, ‘Let's do a Pap smear, I know it's uncomfortable for trans guys to do Pap smears.’ And I said, ‘Well that's not why it's uncomfortable.’ You don't have to assume that it's uncomfortable 'cause of the trans issue. There are a myriad of reasons why that test is uncomfortable for trans guys and for other people…I could've just been like, I'm uncomfortable because it hurts. (Trans male, 22, interview participant)

### Defining gender

Both the patient and provider contribute to processes that define gender in the clinical encounter. The patient is the subject of this interaction and, therefore, the embodiment of gender as
constructed in the visit. The level of power the provider and patient possess determines their respective influence over the four processes described below. These processes may work to reinforce or challenge the cisnormative conception of gynecological care as “women’s health.” Interactions that tend towards gender disaffirmation undermined the patient’s self-determination and engendered feelings of emotional distress, disempowerment, dysphoria and even violation in patients who did not experience body-related dysphoria at baseline and exacerbated those feelings in patients who did. Gender-affirming interactions instead mitigated feelings of otherness and facilitated greater trust and safety in the patient-provider relationship.

*Use of patient identifiers*

This gendering process of the gynecological visit begins even prior to interaction with the medical provider through the use of patient identifiers, such as name and gender pronouns, by clinical staff. The use of gendered honorifics when calling patients in the waiting room and language on clinic forms may be gender affirming or disaffirming. Participants who received care at LGBT-specialized clinics felt affirmed by inclusive forms with multiple gender identity options, including free response. At the other extreme, forms with exclusive language could explicitly gender the patient and gynecological care.

  My provider makes me fill out a questionnaire beforehand, which asks questions such as ‘Woman’s Name’ and ‘Woman’s Date of Birth.’ Addressing the patient as a woman is unnecessary and offensive, when simply addressing them as ‘Patient’ will suffice. (Male, 41, survey respondent)

Gendered patient identifiers are also used during the patient-provider interaction. Some transmasculine participants felt maintaining birth name on insurance and clinical records was necessary to ensure coverage of gynecological services. Those whose legal and preferred identifiers did not then align faced particular challenges with misgendering by medical providers.

  What’s even worse is when you introduce yourself, if they know your legal name, even if they’re getting the name right, they’re messing up the pronouns all the time. Like, no, no I gave you my name, I’m presenting to you with, you know, a bristly crop of facial hair, this should not be difficult for you. My experience with health care professionals has sort of varied in that regard. (Male, 27, interview participant)
Many transmasculine individuals stressed the impact of medical providers honoring “some of the most basic information” about them (Male with complicated bits, 34, interview participant). A 29-year-old interview participant who identifies as queer/transmasculine described their comfort with their current doctor, despite the fact that medical settings are generally triggering of their dysphoria -

He was so aware about PGPs, like preferred gender pronouns, and you know, for me that made the world of difference. Like, when you go into a doctor and they don’t even, they just assume that you’re cis, and that’s kind of unfortunate and so you know, once somebody automatically, you know, kind of calls you ‘she’ or um, ‘ma’am’, or something like that to where they’re just assuming what your gender identity is because that’s what’s on your records. It’s really, you know, unfortunate, and so I appreciated how he asked, and he wanted to know if I had a preferred name, or you know, um- it makes a world of difference for me.

Transmasculine participants who felt unsafe during the clinical encounter, such as those who had not established comfortable relationships with their providers or had experienced mistreatment, often did not disclose their gender identity and preferred identifiers.

I did not disclose until this past year, when I knew my new provider was open to this info, would keep my confidentiality and knew she was very highly educated and sensitive to my feelings, etc. Prior to this, all of the pink and the type of talk at appts has not engendered my disclosing much at all. TOO uncomfortable. Too much risk involved. (Transgender, 52, survey respondent)

These individuals faced further disempowerment in the subsequently gender disaffirming interaction. One 36-year-old FTM-identified survey respondent reported intense humiliation and shame during a Pap encounter in which they did not disclose their gender identity and instead “pretended to be a straight woman.”

**Naming of bodies**

The terminology applied to anatomy during the clinical visit can map gender onto the patient’s body in ways that align or defy the patient’s self-determined identity. Language used by providers that did not first assess patient preferences, was a signal to transmasculine participants of how their gender identity was being perceived.
I luckily have gone mostly to doctors and NPs that were trans friendly. Yes some still said female anatomy terms which I hate and sometimes I still felt like they saw me as female but no one has said anything that made me feel discriminated against for being transgender. (Transgender, FTM, 25, survey respondent)

Transmasculine participants expressed a variety of preferences for naming body parts and perceptions of the gendered implications of those names. Several participants saw the naming process as a way to differentiate their bodies from those of cisfemale patients.

Medically there is a tendency to not feel like it's okay to deviate from what the medical norms are. One time, [my doctor] referred to my, um, body, and she was referring to a specific part of my body, and she said, ‘your clitoris.’ I don't use that name, and I totally understand why it's hard for someone to not use that name, because they're just thinking, ‘This is the name of that thing, why would I call it something different?’ Right? But, like, to me, it's like a matter of like, well, this is the way that you have been taught that a female body is, and this is what this part of a female body is. The reality is, a guy like me starts thinking, alright, well I have somethin' different, because first of all, I have somethin' different because of the way I think about my gender identity, second of all, hormones are changing the way my body is, I don't actually have a traditionally female body anymore, so why should you treat it that way? Yes, when I look down there, I don't see, you know, what I want to see, but I see somethin' a little bit different and I wanna hang on to that, and claim it as much as I can, so maybe I can call it different names.

(Male, 24, interview participant)

Rather than using alternative names for body parts, many other participants sought to avoid invoking gender during the exam altogether by using nonspecific terms to reference body parts, e.g. “inside” versus “vagina.”

Being more sensitive about labeling my parts would be helpful…I would avoid any language that feminizes the process and try to make it much more of a healthy medical thing that has to be done to keep you safe and healthy and doesn't reflect your gender.

(Transgender, Trans man, FTM, 30, survey respondent)
While the majority of transmasculine participants did not want traditionally female anatomical terms applied to their bodies, a few participants preferred their use.

She mostly sticks to, you know, fairly scientific, you know, ‘vagina, vulva, labia,’ you know, again my grandfather was a gynecologist, I sort of grew up with that, you know, having at least a bit of that information, and having access to sort of standard scientific and medical terminology, um, it's less personal and in some ways tends to be sort of less uncomfortable. Um, just because it's just a straightforward description of parts, it's not personal, it's not labeling, you know, it's just strictly anatomical. (Trans man, 49, interview participant)

Another 23-year-old Male/Transmale-identified interview participant used alternative terms for his body in social settings. However, he would like providers to use “medical terms” in the clinical setting to delineate the gynecological exam from a “social thing,” as long as providers first obtain his consent to do so. He felt the clinical interaction did not reflect his socially constructed gender if he was able to perceive the exam as a neutral medical procedure.

Invocation of gender norms and stereotypes

The patient, provider and clinical environment may call forth stereotypes about men and women that contribute to the overall process of defining gender in the clinical encounter. These stereotypes were both enforced internally by transmasculine participants and imposed upon patients externally.

The sense of various internalized gender norms around bodies and sex was heightened during the gynecological visit. Some participants referenced the sexual norm that penetration is a feminine experience to explain feelings of emasculation during the speculum exam -

At this point I see those parts of my body as male or as congruent with my gender identity so it doesn't trouble me too much in that sense, but I have felt dysphoric about being penetrated in the past and sometimes still. (Transgender, Genderqueer, Trans man, FTM, 24, survey respondent)

One participant felt that undergoing a pelvic exam would be like “consenting to be raped” for this reason (Genderqueer, 42, survey respondent). In contrast, transmasculine participants who used their genitals for sex tended to feel less feminized by the speculum exam. A 34-year-old
interview participant who identifies as a male with complicated bits explicitly invoked the stereotypically masculine pursuit of sexual gratification as an affirmation of his gender identity -

I'm very pleasure-driven, and there's a lot of pleasure to be had from that entire area. So, ah, I think that my perception of myself as manly owing to my sex drive is more important than or more psychologically significant to me than my perception of myself as womanly because I'm possessing a vagina.

Part of the distinction transmasculine participants perceived between being treated “like a woman” or “like a guy” by medical providers was often based in the gender stereotypes and norms providers reinforced during the visit.

You work so hard to own your identity as a male person, you know, you do all of the male things and use the men’s room, and the men’s locker room, and wear the appropriate clothing and present your identity and you know, own your identity, and then you have to go do this thing that sort of socks you in the brain that says ‘You still have these female parts, and this doctor is potentially going to treat you like a woman when you are not’…Going to an intimate doctor who doesn’t, or who can’t, or isn’t good at acknowledging your identity creates dysphoria and doesn’t make you want to go. (Male, 27, interview participant)

Language and forms of communication were mediums through which gendered stereotypes were made explicit and applied to transmasculine patients. For example, providers signaled with the reference of stereotypic female undergarments that they perceived their transmasculine patients as they did their cisfemale patients -

When I like got the paper gown on I was so nervous I couldn't take off my underwear and I was wearing briefs which were very obviously, very clearly briefs, and she like, just casually, like as I'm like getting set up and everything she's like ‘Okay, can you like take your panties off now?’ (Male, 26, interview participant)

The tone of spoken and unspoken communication in the patient-provider interaction could also feel masculinizin or feminizing. One participant juxtaposed condescending tones and use of terms of endearment like “dear” that are used in stereotypic communication with women to his preference of being spoken to “matter-of-factly” (Man, 53, interview participant). Firm handshakes and emotional restraint were other types of stereotypically masculine exchanges that
some perceived as gender affirming, with the caveat that exaggerated performances of masculinity by providers could feel as if the provider was “overcompensating” (Transgender, Transsexual, Trans man, Male, FTM, 21, survey respondent).

The surgeon who did my double mastectomy, uh, you know, he clearly had some sort of training, so he, like, went out of his way to show me that, like, I was his, like, male buddy. So, he was like, 'How are ya, buddy?' You know, giving me a manly handshake, you know, and like, you know, going out of his way to, like, make sure that, like, I knew that he knew… It was a little like- I could see what was happening, but like, you know, he was clearly trying. (Male, 27, interview participant)

A few transmasculine participants also felt feminized during the patient-provider interaction if a provider automatically had a chaperone present during the exam without first assessing patient preference. The heteronormative stereotype that women are unsafe alone with men was implicit in this unilateral decision -

The weirdest thing is that when I used to have a male doctor, they would require that a female nurse come in and be present for the pap also and that weirded me out because it was somehow as if the rules perceived me to be safer with a female present when I'm not female identified myself. (Transgender, Genderqueer, 28, survey respondent)

The physical clinical environment was another means of reinforcing gender norms and stereotypes. Gynecology-specific clinics were particularly problematic. In addition to the presence of predominantly femininely presenting individuals, décor and health education materials in exam and waiting rooms that cater to hegemonic femininity delineated clinics as “women’s spaces.”

This setting is also a very special space for women, often. They do not want the invasion of men, esp men they do not know, in these areas of care. Everyone would feel much better if the orientation of the decor was gender neutral, etc. (Transgender, 52, survey respondent)

These physical cues contributed to participants’ formulation that accessing “women’s health” is something set apart, something private, and something “sacred” but vulnerable and susceptible to invasion. Sexist stereotypes and norms about “female” bodies, like vulnerability and
concealment, are thus materialized in “women’s health” clinics. Transmasculine participants are disaffirmed in gynecology clinics, as these stereotypes are then associated with their care. The gender disaffirming effect of reminders that gynecological care was considered “women’s health” was compounded for individuals who noted that male health and bodies are considered the standard from which all others vary. Transmasculine individuals are denied the normative status of cismen when engaging in “women’s health” practices and are thus doubly othered by way of female and transgender associations with their bodies.

Do prostate exam questionnaires ask for the ‘Man's name’ or the ‘Patient's name’? So why is it that just because it's a female-specific test we have to be called women? (Male, 41, survey respondent)

*Representation of gender as biology*

Equating body parts to gender identity was another process through which gender was defined in the clinical encounter. Namely, the conflation of female gender with vaginas, cervixes, and other internal pelvic organs was identified as the dominant cisnormative narrative of gender and biology and was a powerful means of gender disaffirmation that the provider, patient and/or clinical setting could perpetuate or resist.

When society comes down to it, the big thing that, you know, society says [is] that your parts are you, and it's like, when someone's, like, looking and dealing specifically with my parts, it's like, I don't want that to be me…I don't want them to see me as my parts, because well, they're not me. (FtM fluid, 21, interview participant)

Many transmasculine participants found gynecological care generally, and Pap tests specifically, to be a moment during which awareness of the cisnormative narrative of gender as biology was overwhelming due to the intense focus on genitalia.

As someone who identifies as male- doesn't necessarily identify much on the trans spectrum specifically, where a lot of people have found their comfort with feeling like they’re trans, which means that their gender identity is different from possibly what is very normative, and that their biological self is also not normative, and that's okay with them, they've embraced that…That's not how I feel, and because of that, I continue to feel like the only way for me to be at peace is for me to not think about both my biology
completely and myself at the same time…at certain times, like a Pap smear, I'm gonna have to think about that, and it is everything that reminds me what the world sees as female in me, um, and so I don't like to deal with those parts, and you know, if the world did not see these parts as female, I probably wouldn't have a problem, but they do. (Male, 24, interview participant)

Heightened awareness of cisnormativity during the pelvic exam incited feelings of otherness in addition to potentially exacerbating an individual’s gender dysphoria.

I would assume that 99/100 people (think Family Feud-style polls) would state that Paps are for women exclusively. If I weren't trans myself, I might think this too. So, having to get a procedure for women done, as a man, feels pretty gross. This is not because there is anything wrong with being a woman, just that I am not one. It's sort of like when you are taking a medication for an off-label use. When you read the package insert, almost none of it applies to you. Yet, you and your provider have decided that this is the right medication for you. And it works! But, reading the package insert just reminds you that people have forgotten about you and you're not like everyone else. Maybe you aren't so emotional about package inserts, but you know, it's sort of like that. (Transgender, Male, 26, survey respondent)

Underlying cisnormative assumptions of gender as biology were made explicit and enforced by providers when gynecological care was framed as “women’s health” during the patient-provider interaction.

It's uncomfortable for me as someone who does not identify as female to schedule an appointment that's typically seen to be a women's health issue. It doesn't help when, like instances with my most recent primary care provider, the doctor tells me to ‘Go to the front desk and schedule a well woman's exam,’ knowing how I identify, my experiences, etc. (Transgender, Trans man, 26, survey respondent)

In addition to reinforcing stereotypes about “women’s health,” the systematic gender exclusivity of some gynecological clinical settings, as described above, represented institutionalized cisnormativity and necessarily communicated that one’s body parts determine one’s gender.
Transmasculine and provider participants utilized different strategies to challenge the dominant narrative that only women receive Pap tests. Some transmasculine participants claimed Pap tests as part of the experience of being transmasculine or “this other way of being a guy,” rather than a female experience that some masculine individuals must also be subjected to. (Trans guy (FTM/genderqueer), 38, interview participant)

Fortunately I do not have any issues with them. They are a part of life as an ftm transsexual. I have been lucky with the doctor and clinic I attend and it has never been a problem. To them I am a guy with special care requirements. (Transgender, Transsexual, Trans man, FTM, 26, survey respondent)

Several participants expanded the conception of gender as biology to include nonnormative configurations of gender and body parts. Some transmasculine participants linked their body to their masculine identity and rejected the association of their physical self to the female gender.

People have their ways of, if not thinking of their parts as like traditionally men’s parts—you know like penis, testicles and all of that, you know, fun stuff—but at least thinking of them as male parts. Like, ‘I’m a male person, these are part of me, and therefore they are male,’ if that makes sense. (P17, Male, age 27)

For other individuals, body changes secondary to hormone therapy allowed for differentiation from normative female anatomy and facilitated this redefining process -

I think physically what the testosterone has done is created even more of an in betweenness that I actually really like and feel comfortable with. I don't even really see them necessarily as female parts. I seem them as kind of that in betweenness of them. (Trans male (but somewhat fluid), 33, interview participant)

Another strategy used by providers as well as transmasculine participants was removal of any specific gendered connotations from Pap tests. Efforts to present the Pap test as gender neutral included generalizing the experience to all genders or removing all references to gender, often by focusing on aspects of pathophysiology and preventive health.

I think explaining to the patient exactly what the Pap smear intends to do and that you don't get it just because you're a woman, it's because if you have been exposed to HPV and if you have a cervix, that's what we're looking for. It's to protect them against, you know, cervical cancer and that when you remove the whole gender, it's not something
that girls do, it's something that people with cervixes do, then, um, I think that's really helpful (Cisfemale, Internal Medicine, Physician)

Other transmasculine participants framed Pap tests as part of the unavoidable all-gender-encompassing “human experience” of uncomfortable sexual health care (Trans guy (FTM/genderqueer), 38, interview participant).

I feel like for you know, men quote-unquote they have to take care of their parts too right, so it just looks different. They probably have really awkward experiences too. In terms of what I’ve heard, in terms of like testicles, and having a penis, and coughing and all the that stuff that goes along with that stuff. I feel like reproductive things are awkward for you, regardless of whatever body you’re in, and you have to take care of it. I don’t know if there is anybody who is high-fiving about going to the gynecologist or going to have to like, talk about their reproductive parts. (Queer/transmasculine, 29, interview participant)

**Exerting control**

The patient and provider engage in processes that reinforce or challenge the balance of power with which they enter the interaction. The locus of control in the visit consequently shifts further towards the provider or patient, respectively. The subjugation of patients through any of these six processes and/or the gender-defining processes described above may be met with resistance or deference. Patients who felt disempowered in their interactions with providers reported traumatic care experiences with lasting harmful effects, such as persistent distrust of providers and delay or avoidance of future care. Patient empowerment instead facilitated rejection of provider mistreatment, self-advocacy, feelings of safety in the clinical encounter, and agency over body and health.

**Consent and compliance**

Processes of consent prior to and during the physical exam were identified as a form of transferring control to the patient. Relatedly, compliance with or denial of the other’s requests during the patient-provider interaction was another form of exercising control in the encounter. Most provider and transmasculine participants highlighted the importance of the provider making explicit statements that indicated the patient had complete control over the exam.
Many provider and patient participants stressed that the ultimate decision of if/when to proceed with the Pap test was the patient’s alone to make. The provider role in a collaborative patient-provider relationship was to support patient agency by ensuring that patient decision-making was informed.

She also puts it in my court where she never makes me feel like it’s something that has to happen…If she disagrees, she’ll push back and say, ‘As a doctor, ethically I have to tell you that this is not the thing I would recommend. Here’s why…As your doctor I’m going to be worried about you, and I think it’s stupid not to do it, but you are entitled to do what you want with your body, and just know that I will take care of your body in a way that you feel fit.’ (Genderqueer FtM, 25, interview participant)

This communication was paramount with patients who found the pelvic exam distressing to avoid any pretense of coercion. A cismale Family Medicine physician, used this strategy with a patient who initially refused the Pap test -

In that patient I said, ‘Oh, okay this is clearly a challenging issue, and you know, we'll talk about it some more. We're not doing it today; we'll come back to it. Maybe at some point you'll be ready, and maybe you won't.’ I said, ‘I'm not here to assault you about this, you know, this is your health, and you know, we're working together, and if you tell me I'm not to do something, I just document we're not doing that.’

Provider and transmasculine participants acknowledged that the passiveness associated with the patient role during the exam itself could threaten a patients’ sense of agency. Most providers utilized strategies to counter this power imbalance and establish patient control over the exam, especially in moments of physical or emotional distress. Some routinely gave patients “permission” to stop the exam at any time and instructed patients to notify them immediately should they experience pain (Cisfemale, Primary Care, Nurse practitioner).

I always throw in a ‘You're in charge,’ because I think that makes the patient kinda feel like, okay, this isn't something now that's being taken out of my command. So always say, ‘You're in charge, at any point, if you'd like for us to stop, if you'd like for us to do something differently, then you let us know, and that's what will happen,’ before I even put my hands on the patient. So I think that sometimes takes a little bit of that fear away that tends to kind of surround these things. (Cisfemale, Infection Disease, Physician)
Obtaining continual consent during the exam by informing the patient of each step of the process before it happened was another key method of increasing the patient’s sense of control. A 33-year-old interview participant who identifies as trans male (but somewhat fluid) experienced increased anxiety during “aggressive” Pap tests in which providers rushed and did not give “a little bit of warning” while proceeding through the test, in comparison with “gentle” Pap tests during which the provider sought ongoing consent -

The slowness and the communication made me feel like I could easily like, before it happens be like, wait! Or somehow I might be able to control the situation even though I really can't. Um the time between things, having that space, made me feel like yeah, I could at least get to a point where I was close to controlling it even though I wasn't. Whereas the quickness it's completely out of control. Like, no control whatsoever.

Eliciting and honoring patient preferences for the Pap test, including pacing of the exam, was also an important means of respecting a patient’s agency over their own body endorsed by many provider and patient participants. A 21-year-old genderqueer FtM-identified interview participant found Pap tests challenging due to a history of trauma and extensive negative experiences with medical providers since childhood. Past providers have not asked how to make the exam more comfortable, but this participant believed this would allow them to feel more empowered as a patient.

Unfortunately, transmasculine participants reported many experiences with providers who exerted control over their body and exam by not complying with patient requests and preferences or not attaining adequate informed and ongoing consent.

It was just no matter I told her, like, ‘I need you to go slowly, or I need you to like give me like a second to like, catch my breath before you do something’ - she would just kinda like, ‘oh, well, whatever.’ Like, kinda just waved me off and just like, ‘I'm the doctor, I know what I'm doing. I've practiced on cadavers and whatever.’ (Male, 26, interview participant)

At least nine transmasculine participants reported pelvic exams during which the provider ignored their complaints of pain and/or ignored their call for the exam to stop. These experiences
of extreme violation left participants feeling dehumanized and several likened the nonconsensual exam to rape.

It felt like more like a piece of meat in front of them, I guess would be a way to say it. So that if you hurt or said something back to them, it was more like you were being annoying or irritating to them. I don't know if that makes sense, but something like that. (Trans male/genderqueer, 50, interview participant)

When asked what advice he had for providers performing Pap tests on transmasculine individuals, one interview participant stated -

Listen to your patients. Put your ego aside, it's not about you. Your patients are not being whiny little babies. Just, you know, first thing in the Hippocratic oath, first do no harm. 'Cause shaming your patient, disregarding your patient's comfort and needs, that's doing harm. Whether it's physical harm, whether it's psychological harm, it's harm. Don't fucking harm your patients. (Male, 26, interview participant)

\textit{Interpersonal discrimination}

Interpersonal discrimination that occurs during the gynecological encounter undermines patient safety and may compound vulnerability in the context of already sensitive care. Transmasculine participants were subjected to transphobic, homophobic and fatphobic provider behavior during the clinical visit that ranged from microaggressions to outright expressions of bias, rejection and disgust.

It's not pleasant for me no matter whatever. But I think for trans men especially if you got issues around body or body safety, past traumas, past unpleasant Paps…I had an abortion where the doctor screamed at me, ‘If I had known you were so fat I would’ve had you go to the hospital!’ It was horrible. So you need to be proactive. (Male, 56, interview participant)

Transmasculine participants’ capacity to resist ongoing discrimination during the clinical visit varied according to the level of patient empowerment. Those who were “going in strong” were more readily able to immediately reject provider mistreatment (Transmasculine, 23, interview participant). However, scarcity of care was cited as a major constraint on decisions to end the visit prematurely and seek care elsewhere or at all.
The doctor I had made several comments about how I reminded him of his daughter, than it was a shame since I was pretty, etc. I only went through it due to the fact that I had a problem I was concerned about and I had not yet found my current doctor. (Transgender, Transsexual, Trans man, FTM, 26, survey respondent)

These experiences had a lasting impact on some participants’ sense of empowerment in future clinical encounters, as participants had more difficulty feeling safe in medical settings and trusting providers. A 35-year-old trans/queer-identified interview participant remained wary of unfamiliar clinical settings after being discriminated against by medical providers on the basis of their gender identity -

I think that I would probably always feel safe having a pap if I was in a safe space, but um, I wouldn't, like if I had to go have a pap somewhere else right now, I think that this would be a completely different conversation.

Adherence to norms of professional language
Providers defied expectations of their impartiality as arbiters of science by referencing patient bodies in casual or nonscientific ways. Transmasculine participants described providers using unnecessary judgment terms like “pudgy,” “perfect nipples,” and “manly-looking legs.” Patients perceived these providers to be motivated by their own personal curiosity/voyeurism in lieu of patient health and were left with feelings of being on display and violated.

When discussing changes in my body since starting testosterone my primary care doctor asked, ‘Have your breasts always been that small?’ The way he phrased this question left me feeling extremely violated and dysphoric. A better way to phrase this for me would have been, ‘Have you noticed any change in your chest/breast size since starting HRT?’

A bad experience with one doctor can really limit the likelihood of returning to care and opening ourselves up for that type of vulnerability and abuse again. (Transgender, Trans man, 26, survey participant)

A 42-year-old survey respondent who identifies as transgender, male, FTM and a trans man, felt “tons of gender and fat shame” when notified that the provider needed to find a “bigger” speculum. Commentary on medically irrelevant characteristics of the patient’s exposed body during the physical exam, like tattoos and genital piercings, also increased transmasculine participants’ feelings of scrutiny and non-neutral evaluation. Notably, a cisfemale Primary Care
nurse practitioner made it a conscious effort to avoid charged or overly casual language during the pelvic exam to prevent any appearance of impropriety, such as referencing speculums by color and not size and substituting the word “gel” for “lube.”

Negotiation of transition-related care
Some transmasculine participants received gynecological and transition-related care from a single provider. For these individuals, negotiations with provider gatekeepers in order to maintain access to transition-related care became a part of the gynecological visit. These negotiations were necessarily imbalanced and had the potential to unduly constrain a patient’s decisions about their own health. Twelve of our transmasculine participants explicitly expressed the belief that cervical cancer screening was required to obtain or continue on testosterone therapy. Coercion to undergo an invasive and potentially traumatizing test, whether intentional or not, resulted in profound disempowerment of patients for whom barriers to already scarce care were immense.

The worse is when I went through HOURS of being around and the women STILL was rough and I just told her to stop and she wouldn't give me my hormones until I did this so I was without hormones for 2 years…It's the worse thing and I'm often depressed for many weeks after. (Transsexual, Trans man, Male, FTM, 52, survey participant)

Several transmasculine participants also felt obligated to eschew their own self-concept of gender identity and conform to medical definitions of transmasculine identity for approval of transition-related care.

I always felt maybe a combination of both, not really, somewhere in the middle? Or, not, there was no real term. And it's just, you know, once I decided to, um, I wanted to go on the male hormones, um, I had to sort of box myself that way. Even though I don't really fit. (Trans, 53, interview participant)

The same cisfemale Primary Care nurse practitioner mentioned in the preceding section sought to counter these effects and preserve patient agency over body and identity by explicitly affirming that decisions around transition-related care were not contingent on preventive gynecological care.
Breaching the body

Most transmasculine participants considered the speculum exam to be an invasive procedure and a moment of vulnerability for all genders. Nudity and the lithotomy position, in addition to speculum placement and the Pap test itself, were identified as major factors contributing to the invasiveness of the exam. Participants differed in what they considered the most invasive aspects of the exam.

My biggest discomfort with that is the like, getting undressed and being naked, or that cloth, or whatever the paper thing, um that is way more uncomfortable to me than when they’re actually like doing the pap itself. It’s the initial taking my clothes off and being like pretty much naked and then having to lean back and like, ‘Open the legs’ and stuff. (Trans* ftm, 29, interview participant)

Feelings of intense exposure and vulnerability while undressed in the lithotomy position could lead to significant emotional distress -

The thing that makes me the most uncomfortable would just be the idea that I’m laying there with my legs up on these little stirrup things and having somebody so close to that area…You know, when you’re like that, you’re exposed, and you’re open, and um it can be very jarring…When you feel very vulnerable, you get that kind of fighting sense of like, I don’t want someone to do this. But you know, what are you going to do, kick your doctor in the face? Like, that’s awful! So that would be the most uncomfortable, is feeling that fight-or-flight sense while I’m sitting there vulnerable. (Male/Transmale, 23, interview participant)

The level of vulnerability and associated distress experienced during the exam varied across patients. Factors that could exacerbate feelings of vulnerability included a history of trauma, internalized sexism and transphobia, fear of judgment, and dysphoria. An interview participant with a severe trauma history reported having flashbacks and dissociative episodes during past pelvic exams and found Pap tests traumatic before he received care for PTSD (Male, 56). Several other participants experienced distress associated with internalized stereotypes about the shameful and uncleanliness of “female” genitalia, including concerns about secretions, odor, hair, and modesty.
There is a bit of a stigma. Not just for trans men, but, you know, also for women in general. Because I mean, anybody who has a female body is usually taught to be a bit embarrassed about it. They’re taught to cover up, to be, you know, prudish about it...So you still got a bit of that, even though, you know, you’re transitioning, you still have that feeling of, you know, you want to be covered, and you don’t want anyone to see you. So that can definitely put a step into it, that can definitely, uh, make it a little harder.

(Male/Transmale, 23, interview participant)

Several participants also endorsed intense shame about the appearance of their genitalia following testosterone therapy.

Since starting T and physically transitioning, I feel so much more uncomfortable hopping up on the table and spreading my legs. I have to engage in a lot of positive, loving self-talk to help make the appointment go smoother. I find myself fighting off facts like, ‘Oh no, this doctor is going to think I'm such a freak’; ‘My legs are so hairy. My body has changed/grown. Is she going to be disgusted by me?’; ‘I don't feel like I have a normal penis or vagina. What is wrong with me? What will the doctor think?’ Prior to starting T, it was a weird, uncomfortable experience, but I felt more discomfort than shame about my body. (Transgender, Trans man, 26, survey respondent)

Nonnormative genitalia were a physical marker of difference that participants had to put on display for evaluation by a figure of authority. Fear of judgment from providers during the exam was a source of distress for many participants, including both those who did and did not express body-related shame or discomfort. A 33-year-old trans male (but somewhat fluid) interview participant who currently receives care at a LGBT-specialized clinic, explained -

I feel like there's just this kind of special environment in this place, but other places I feel like it's a little scary. Uh, 'cause you're already in this very vulnerable position getting a pap, and you also feel very vulnerable having this person who doesn't work with trans people, um, working on your body. And I think that that's just really kind of scary. 'Cause you don't want to be judged while you're lying there and feel violated - you never know what they're thinking and what they're feeling when they're doing this, and I feel like in a place like this it's just like, it's commonplace.
Vulnerability during the exam often increased when transmasculine participants experienced severe pain or had body-related dysphoria. Those individuals with dysphoria specifically associated with their genitals were even more likely to experience the speculum exam as a violation of bodily integrity or self-concept.

The one time I had one, I was extremely anxious and uncomfortable beforehand, and during the procedure felt violated and humiliated. It felt awful to have this part of my body I have struggled so long with feeling dissociated from kind of put at the center of this physically painful experience, and with people (the providers) who were strangers who I did not trust. The doctor and nurse spoke to each other during the procedure and not to me, which didn't help! (Transgender, Transmasculine, 25, survey respondent)

Interactions with the provider could exacerbate or attenuate the invasiveness of the exam. Feelings of violation due to mistreatment or gender disaffirmation could be magnified in the patient’s heightened state of vulnerability.

Definitely substantially larger proportion of the discomfort comes from, you know, how is the provider gonna treat me…And what's sorta triggered by if they say something, and I'm in that like really vulnerable position. Yeah. That could be very emotional, or you know, really blahhhh. (Male, 27, interview participant)

A trusting relationship with the provider administering the exam increased sense of safety and reduced vulnerability for many participants. A strong patient-provider relationship could facilitate a more empowering experience even for those individuals who may have otherwise been most at risk of vulnerability. A 21-year-old interview participant who identifies as male and ftm was “very worried” the Pap test would be distressing given his history of abuse. He explained what facilitated an unexpectedly positive experience -

Um, possibly just 'cause I trust my doctor and my partner was there and it was a very supportive and friendly experience. Um, I know that he wasn't trying to harm me or anything. It was, you know, for the greater good of things and for my health and everything else. So I think the trust factor was the number one thing.
Provider participants also recognized the importance of mitigating patient vulnerability and used a variety of strategies to facilitate patient empowerment and address the invasive aspects of the speculum exam.

I think in a doctor-patient situation, sometimes - and I can't imagine it because I've been who I am for so long - but there's this power differential, and so, if they're getting up into some really vulnerable position in the stirrups, then that's pretty scary because what if somebody does something to them that they don't want? And so I make sure that patients never feel that they're going to be coerced, or anything will happen, that they're in complete control of the situation at all times, and you know, I'm willing to do my job if they'll let me.

(Cisfemale, Family Medicine, Physician)

In addition to careful attention to the consent process (see above), provider participants encouraged patients to bring a support person, offered premedication with anxiolytics and avoided sensitive topics during the exam to promote patient comfort. Other provider participants sought to minimize nudity-related discomfort by allowing patients to keep their shirt on during the exam or conducting all discussions prior to the exam while the patient was clothed. At least one provider participant attempted to position patients who found the lithotomy position challenging without footrests when possible (Cisfemale, Primary Care, Physician Assistant). A few providers also offered speculum self-insertion to increase patient control over a highly vulnerable aspect of the exam. Various transmasculine participants endorsed these strategies.

I know that it’s like important to have a chest exam, but if I could have the shirt on until then, I think that would make a big difference - I think I would feel a lot less stressed, since my biggest thing with the pap smear is like the being undressed, and even if I’m draped in that paper thing, I just feel like it barely covers you, and also like the sensation of my chest. (Trans* ftm, 29, interview participant)

A 28-year-old interview participant who identifies as a trans guy found speculum self-insertion increased their sense of control over the exam -

I think that it was much easier when I was getting the pelvic to like, be able to just guide it in a way that like, felt more empowering, and less um, like something that was happening to me and something that I was able to take part in.
Objectification

Interactions with the provider determined whether the pelvic exam or clinical visit as a whole was a dehumanizing experience. Several transmasculine participants felt reduced to mere body parts during Pap tests due to the manner in which the test was conducted.

It's so perfunctory that its like, ‘Oh here we go again, here's another vagina I gotta stick this damn thing in, open it up, blah blah blah, yup okay honey, here's your swab, go.’ You know? I mean that's almost too perfunctory. I wouldn't be comfortable with that kind of exam regardless of what part of my body is being examined. (Man, 53, interview participant)

For other participants, exams that were performed too quickly felt “transactional” or like an “oil change where they just shove and scrape” (Queer/transmasculine, 29, interview participant; Trans male (but somewhat fluid), 33, interview participant). The demeanor of some providers left transmasculine participants feeling divested of individuality throughout the entire encounter.

They're sort of on autopilot as they go through the process, you know, you can kind of tell they're checking off little boxes, and they're just doing something to do it, not because they have caring for me as a person or as a patient, and I like to feel like I'm being engaged with in the moment, and that my providers are present for me throughout. (Trans man, 49, interview participant)

In contrast, humanizing encounters often occurred with providers that showed personal caring and tailored care to the needs of the individual patient.

The fundamental part to me is that when you ask me, ‘Do you have a positive Pap smear?’ and I said, ‘Yes, I did’, and then you talk about all these different details that I told you I don't like - the fact that I had a positive experience had to do with the fact that my doctor connected with me on a human basis. She made me feel comfortable, she made me feel like she acknowledged my discomfort…That's the first thing I'd say, when you approach your patient, don't think about this as just a procedure. You're a primary care doctor, and the care that you give most of the time is not necessarily just medications, the care that you give is giving a sense of care, and that sense of care comes together with a connection with that patient, so make sure you kind of start connecting on the issue, and just kind of have a conversation about it, tell the patient why you think it's
a good idea for them to have it, ask the patient why don't they wanna have it, ask the patient, ‘How can I make you more comfortable?’ (Male, 24, interview participant)

**Othering and Pathologizing**

Transmasculine participants described a dichotomy between being othered and pathologized (i.e. being viewed as fundamentally different or abnormal, respectively) versus being granted personhood in the clinical encounter. The interpersonal interaction with the provider and the clinical environment could generate or exacerbate a patient’s internal sense of being a “medical oddity,” “abnormal,” “wrong,” “weird,” or “different.”

A trans guy is pretty different. Um, things have, you know, changed. Um, so I believe I’ll feel a little bit more uncomfortable because it’s like in that weird between-area. I’m not really where I was when I started. You know, kind of the average…I guess to people who aren’t trans, it’s an interesting thing. It’s like one of those like, ‘Huh, you know, that’s different.’ So I worry sometimes that things - I don’t know how to explain. It’s not really judging as much as there’s just like, ‘Well, that’s weird.’ (Male/Transmale, 23, interview participant)

A few participants felt they needed to purposefully self-pathologize their identity or relationship with their body in order to gain validation from providers controlling transition-related care.

Gender-wise, a lot of the time I'm totally okay with having a vagina. I am not okay in having a vagina in the doctor's office. There it feels like a problem, and like I'm supposed to present it as a problem in order to keep getting T. (Genderqueer, Trans, Queer, 25, survey participant)

Cues from the provider that could augment patient feelings of difference included general demeanor, the level of familiarity with transmasculine patients, and any reactions to the patient’s body. Transmasculine participants reported providers who assumed they had a pathological relationship with their bodies, similarly to some of the provider participants in our sample. The fearful demeanor of a provider could be “anxiety-producing” and indicate there was “something wrong,” even if the patient did not have any prior anxiety about the exam (Trans guy (FTM/genderqueer), 38, interview participant). A cisfemale physician assistant in Primary Care
practice also acknowledged the effect her own expectations of patient discomfort inadvertently had on the patient’s perception of the exam -

I think the one thing that changed for me is when I first started doing them, I think I assumed that every guy would have a hard time and would hate doing it, and I think that I would automatically go into it being like, ‘Oh, I'm so sorry’ and I think that, in some ways, I was transferring my - and I think in becoming more comfortable and realizing that it's not bad for everyone, or asking about it, I think has helped a lot and then it's not as big of a deal. But I definitely remember being like, ‘It's time for the Pap!’ you know? And then they're gonna be like, ‘What?!’

The demeanor of a provider could also be interpreted as a complete pathologization of the patient.

Doctor needs to see me as a person and treat me like I matter and I am cared for. Not like some poor excuse for a human being that is so freakish and they need to finish quickly.

(Transgender, Transsexual, Trans man, Male, FTM, 49, survey respondent)

In addition to nonverbal cues, a few transmasculine participants noted explicit reactions to their body.

Someone asked me if it was normal that my clit was so big. Not helpful in the context of getting a pap. Had something with the exam that was wrong (they couldn't get a sample and needed to re-do it, I think). I didn't go back. (Transgender, Trans man, FTM, 35, survey respondent)

Transmasculine participants were more likely to feel like a “medical oddity” or perceive the provider’s demeanor as rejecting if the provider was not familiar with transmasculine patients.

You could go to a gynecologist and be like, ‘Oh, I’m trans,’ and they’ll be like, ‘Oh, that’s fine!’ And really, they’re just not. They’re not fine. They don’t know what they’re expecting, and they don’t know what they’re really looking for, and they don’t understand that trans men’s body, they change when they’re on T. Um, you know, things aren’t, forgive my language, but they’re not lubricating the same way. Things are different. Um, and so that could be jarring to someone who’s never really dealt with trans people, at least on a regular basis. And it can definitely, you know, make you more nervous, because they’re probably confused and a little nervous. And, you know, they
might get a little apprehensive as well. Like, you never know. It’s these subtle, little things that you can kind of see. (Male/Transmale, 23, interview participant)

A 25-year-old genderqueer FtM-identified interview participant believed the “main source of dysphoria” about their body was awareness that it was “not the norm.” Their dysphoria was triggered by the reaction of a medical student who presumably had not examined a transgender patient before -

I will say for a medical student, she was phenomenal about it, and I could really tell like, was trying to check herself. But it was still like, okay, I feel like I’m on show right now…You could tell she was taking it all in a very respectful way, but it was still like a surprise, and still, um, understand again about that point of difference, that if I were someone who was cismale and getting any sort of regular checkup this wouldn’t be a surprise to you.

Gynecological care was normalized when providers did not make assumptions about the patient’s discomfort or experience and did not make the exam “a big deal” (Transgender, Genderqueer, FTM, 49, survey respondent). Assessing patient comfort was still critical in normalizing interactions, but this was done in a “matter of factly supportive” manner (Trans man, FTM, 50, survey respondent).

My doctor did my last GYN exam and did a great job just being his normal self and asking beforehand if I had any concerns/worries and was quick in the process.

(Transgender, Trans man, FTM, 31, survey respondent)

For many participants, being treated normally equated to being treated just like any other patient and being recognized first and foremost for their humanity, not gender identity. A 21-year-old male, ftm-identified interview participant described his supportive and open relationship with his primary care provider -

He's ok with me being a guy. He's ok with me being gay and that's fine. You know, we go in and he'll just ask me how my geckos are. And, you know, it's not about the, ‘Oh, so how is this and this-’ It's just like, ‘Hey, how's your life going?’ Just like any other person. I'm just another person. I don't want to be something else. I'm just me. And that's it. And, that's how he treats me and I think that's great.
Feelings of difference and erasure were compounded in gender-exclusive clinical settings. In addition to gendered décor, the types of bodies represented in images around the clinic were an institutionalized endorsement of what was considered a healthy and normal body.

So like for me the images even that you see on people’s walls when you go into a doctors office and you’re like, well, no one up there looks like me, so do they have the knowledge of people who are like me? You know it would be awesome if I could walk into somebody’s office and they had someone who has a kind of a non-binary body you know or nonnormative body in the sense that like - the fact that I saw somebody with hairy boobs, I was like ‘Awesome!’ You know that’s a possibility for somebody, that there are people who live like that. Or somebody who has a buzz cut and they’re not transitioning, but they identify as masculine, and they identify as trans and this is what their body looks like whatever, you know. When I go into offices I’m like, ‘Oh cool, you have fit, white men on the wall.’ (Queer/transmasculine, 29, interview participant)

LGBT-specialized clinics that “cater to difference” were recognized as places of comfort, safety, affirmation and inclusion (Trans male (but somewhat fluid), 33, interview participant). A 31-year-old genderqueer interview participant explained -

It's not like I show up to like the women's health clinic or that like, there's a lot of things that are overtly like, ‘women, women, women,’ um, you know, because then I think it would just feel a little odd, because then it's like, you feel more like an anomaly…Um, you know even if I was treated really respectfully, I think it just feels weirder, and the fact that like, you know, all sorts of stuff is happening, it's just another part of your care, and there's all different types of people, it just doesn't feel particularly strange.

V. Discussion

Multilevel factors affect the baseline level of power with which a healthcare provider and transmasculine patient enter a clinical interaction. Though the default power dynamic at the encounter onset is undoubtedly skewed away from the patient due to systematic cisnormativity and the authority ascribed to the provider role (Goodyear-Smith & Buetow, 2001), the specific
configuration of power and gender that subsequently manifests during the visit may take different forms in different clinician-patient duos. Both patient and provider participants described processes that function internally, interpersonally and institutionally to define gender and shift the locus of control during the visit. The interplay of gender and power dynamics ultimately determines patient agency and experience of care. Gender disaffirming interactions undermine patients’ self-identities and thereby thwart their capabilities for autonomy (Entwistle et al., 2010). Disempowerment reduces patient capacity to assert self-determined gender and resist misgendering in the encounter, leading to a vicious cycle of ongoing gender disaffirmation and disempowerment. Both the contextual factors that shape the power of transmasculine patients and providers prior to the encounter and the distinct mechanisms of power and gender construction in the visit are thereby crucial to understand in order to determine how best to intervene to support patient agency in the clinical context.

Factors influencing initial patient empowerment and resilience included experiences of intersecting oppression and privilege, interpersonal trauma and affirmation, self-affirmation, and health literacy. Our data support the importance of recognizing that the resilience of transmasculine individuals cannot simply be attributed to inherent intrapersonal traits, but rather is shaped by structural and interpersonal level factors (Colpitts & Gahagan, 2016). Both patient and provider participants described the effect of widespread, multilevel stigma on vulnerability to external stressors (Grant et al., 2011; White Hughto, Reisner, & Pachankis, 2015). However, experiences of institutional erasure, interpersonal discrimination and violence, and internalized stigma varied according to the other marginalized identities and privilege an individual possessed (Ross, Law, & Bell, 2016). Factors that bolster resilience are similarly interconnected. Economically and racially privileged individuals were better positioned to achieve social, legal and/or medical transition goals that facilitated recognition by others and living in alignment with one’s self-determined gender. Subsequent interpersonal affirmation and support and self-affirmation promoted resilience in numerous settings, including healthcare, as demonstrated elsewhere (Colpitts & Gahagan, 2016; Ross et al., 2016; White Hughto et al., 2015).

The authority of the provider derives from both external and individual factors. While the provider role as impartial arbiter of science is general to the care of all patients, gate-keeping of
transition-related care due to the medical model of transgender identity and the scarcity of providers willing to care for transgender patients are structural factors related to the current state of transgender health care in the United States (A. H. Johnson, 2015; Spade, 2003). These factors further magnified provider power and the risk of disempowerment of transmasculine patients. The potential for power imbalances to beget further power plays (Pauley, 2011) was evident in a tremendously concerning phenomenon specific to gynecological care - several participants felt coerced to undergo an invasive exam due to the belief that receipt of a hormone therapy prescription was made contingent on completing cervical cancer screening.

Several transmasculine participants were turned away from care by providers who cited inexperience with transgender patients. The exclusion of transgender health topics from medical training has been widely recognized as a source of provider discomfort with transgender patients (Poteat, German, & Kerrigan, 2013; Snelgrove et al., 2012; Stroumsa, 2014; White Hughto et al., 2015). However, multiple clinical guidelines existed at the time of this study (Coleman et al., 2012; Feldman & Goldberg, 2006; Hembree et al., 2009; Deutsch, 2016), and provider participants who did not work in LGBT-specialized clinics reported greater ease in caring for transmasculine individuals through self-directed learning. Given that continuing education is a standard expectation of medical professionals and availability of resources, lack of prioritization of transgender health by medical societies and individual providers also contributes to scarcity of care for transmasculine individuals.

It is notable that even provider participants with considerable experience providing gynecological care for transmasculine individuals displayed a persistent inability to reconsider the genderedness of bodies and the Pap test. While there may be no “manly speculum,” we reject the implication that there exists anything inherently womanly about having a cervix or undergoing an examination using a device designed to visualize this body part. The reproductive dichotomy is assumed to be the definite basis of gender in our culture (i.e. cisnormativity), yet Connell (1987) argues our understanding of what is natural “is itself a cultural construct, part of our specific way of thinking about gender.” It follows that social practices do not simply reflect “natural sex differences,” rather; they “weave a structure of symbol and interpretation around them, often vastly exaggerating or distorting them.” The body does not stand immutable outside
of the social processes of gender; its biological characteristics are worked on, transformed and given a social determination through these processes (Connell, 1987).

Connell (1987) notes that much of the “work” a transgender individual assigned male at birth does to sustain an identity as a woman is also done by ciswomen, but in the latter case, it is taken for granted as natural and not noticed as work. Similarly, an extensive amount of unseen effort is required to maintain the womanliness of reproductive and sexual health involving vaginas, cervixes, and uteruses. Perhaps most blatant is the replacement of every mention of “patient” in forms, brochures and speech with the word “woman” and pastel and floral decor, a stark departure from customs in all other medical disciplines. However, transmasculine and provider participants highlighted these and perhaps less visible aspects of multiple processes that iteratively constitute and sustain gender in the gynecological visit, including the use of patient identifiers, naming of bodies, invocation of gendered stereotypes and representation of gender as biology. The importance of subtleties of language noted previously in the literature was again demonstrated, as it was a tool used in each of these gendering processes (Hagen & Galupo, 2014; von Vogelsang et al., 2016).

The aforementioned providers remained ignorant of their active role in gendering gynecological care and sought strategies to increase tolerability for masculine people that did not challenge the perceived femininity of the exam. Consequently, their well-intentioned efforts to increase patient comfort may be thwarted by the gender disaffirmation that results when cisnormativity is reinforced in their interactions (Hagen & Galupo, 2014). Some provider participants who were unable to reconceptualize the genderedness of body parts made the associated assumption that all transmasculine patients must have a negative relationship with their bodies. Not only did this disregard the diversity of the identities and conceptions of bodies held by our transmasculine participants, but also this attributed any dysphoria experienced during the exam to be innate to the individual patient. This attribution is consistent with the medical model of transgender identity, which focuses on embodiment as the source of an individual’s discomfort around incongruence of assigned sex and gender identity versus the “social consequences of gender ideology, transphobia, or cissexism” (Johnson, 2015). The critical impact of external gender disaffirmation by the provider and/or clinical environment on a patient’s experience of dysphoria
during the clinical visit is thus negated. Transmasculine participants with both minimal and severe levels of dysphoria at baseline endorsed the powerful impact of interpersonal and institutional gender disaffirmation.

Our data corroborate other accounts of specific stigmatizing provider behaviors exhibited towards transgender patients (Kosenko et al., 2013; von Vogelsang et al., 2016). We categorized perceived mistreatment reported by our participants into types of stigmatizing processes with distinct effects - interpersonal discrimination, negotiation of transition-related care, othering and pathologizing - to better demonstrate how they function to disempower transmasculine patients and inform future prevention. The other processes through which power is claimed or exchanged between provider and patient are general to the gynecological care of all patients regardless of gender, including mechanisms of ongoing consent and compliance, adherence to norms of professional language, breaching the body, and objectification. However, unique issues may influence even these processes to decrease control during the visit for transmasculine individuals. For some participants, vulnerability during the exam was augmented due to dysphoria or the compounding effects of internalized sexism and transphobia on genitalia-associated shame. Importantly, a trusting and comfortable patient-provider relationship could attenuate the effects of all of these processes and increase the likelihood of empowering care experiences.

Affirming and empowering care experiences were associated with enhanced feelings of safety, capacity to advocate for individual needs and resist mistreatment, and reduction in dysphoria-related distress. Transmasculine participants who instead felt their gender was disaffirmed and agency constrained by the provider in the context of the invasive speculum exam consistently reported traumatic and violating care experiences which for some, resulted in severe emotional distress, persistent distrust of medical providers, and/or decreased care utilization thereafter. The negative impact of gender disaffirming care, mistreatment and disempowerment in healthcare settings on delay and avoidance of care has unfortunately been well-documented in the literature (Bauer et al., 2009; Cruz, 2014; Grant et al., 2011; Johnson et al., 2004; Lombardi, 2001; von Vogelsang et al., 2016; White Hughto et al., 2015). Importantly, both patient and provider participants utilized strategies that resisted cisnormativity and the power differential in order to optimize patient control and affirmation.
Conclusions and Recommendations

The levels of gender affirmation and patient empowerment that occur during a gynecological visit have a profound impact on patient experience and subsequent utilization of care. Disaffirming, disempowering care is a barrier to fulfilling the basic, universal need for healthcare that is safe, dignified and free from coercion, and is out of reach for many transgender people (Hagen & Galupo, 2014). Furthermore, understanding the provider role in power and gender dynamics will be critical to aligning the gynecological care generally, and cervical cancer screening specifically, of transmasculine individuals with important dimensions of patient-centered care, including patient empowerment, sensitivity to the patient as a unique person and the therapeutic alliance (Goodyear-Smith & Buetow, 2001; Mead & Bower, 2000; Rathert, Wyrwich, & Boren, 2013; Scholl et al., 2014). As many of the processes of power and control explored are at work in the gynecological care of individuals of all genders, we would argue that power and gender analyses provide a useful framework to assess and improve this sensitive care for all patients and the recommendations that follow have wide applicability.

The forces that shape the positions of power of the patient and provider upon entering a clinical encounter may not be modifiable in the short term, though clinicians as advocates can play a role in addressing structural factors such as insurance coverage, access to transition-related care, and health professional education in transgender care (Lombardi, 2001; Redfern & Sinclair, 2014; White Hughto et al., 2015). Established providers can seek continuing medical education in transgender care to increase their comfort with transmasculine patients (Redfern & Sinclair, 2014). Within the bounds of the clinical visit, providers can act to modify gender defining and power exerting processes to promote patient affirmation and agency with attention to specific behaviors and the clinical environment (Hagen & Galupo, 2014). Our findings contextualize the importance of many of our prior recommendations for best practices for cervical cancer screening for transmasculine individuals (Potter et al., 2015) and excellent recommendations for general provider communication with transgender individuals put forth by Redfern & Sinclair (2014). Related principles of care and additional recommendations will be highlighted here.

The possibility of gender affirming and empowering care is threatened when providers reject the fundamental assertion that gynecological care and reproductive organs are not inherently
gendered as feminine. We urge providers to pursue self-awareness of the processes unfolding during a visit that actively and unavoidably gender the exam and patient. It is paramount that providers familiarize themselves with and value the incredible diversity of the transmasculine community (Eckstrand, Ng, & Potter, 2016). Assumptions about patient experiences, values, and preferences must be avoided whenever possible to prevent imposing gender constructs and stereotypes that do not align with the patient’s gender (or any other) identity and lived experiences. Patient self-determination can be promoted by ensuring access to transition-related care to gender non-conforming individuals who may not fit clinical stereotypes of transgender identity that reinforce the gender binary (Eckstrand et al., 2016).

Chosen patient identifiers, including name, pronouns, gender identity, and anatomical terms should be assessed routinely with all patients and used consistently. This may necessitate changes to the electronic medical record to indicate those preferences for use in future encounters by all medical staff with clear differentiation from the patient’s legal name or the gendermarker on insurance (Potter et al., 2015; Redfern & Sinclair, 2014). As transgender and gender nonconforming participants have suggested here and elsewhere, inclusive patient intake forms are a valuable method to collect this information (Redfern & Sinclair, 2014; Ross & Castle Bell, 2017). Intake forms can signal clinic familiarity with transgender patients thereby promoting patients’ sense of safety and comfort actually disclosing nonnormative gender identities as well as increasing the visibility of the transgender community to all clinic visitors. Transgender-inclusive statements on clinic websites and clinic materials featuring or tailored to transmasculine individuals can also signal safety and reduce fear of stigmatizing treatment (Potter et al., 2015; Redfern & Sinclair, 2014; Ross & Castle Bell, 2017).

The focus on “women’s health” demonstrated in discussions with patients, clinical settings with stereotypically feminine décor, and gender exclusive clinic names and patient materials is not only gender disaffirming, but also signals difference and effectively others the presence of masculine-presenting people in gynecological clinics. This ultimately prevents normalization of gynecological care for patients of diverse gender identities. While changing the physical appearance of clinics requires time and resources, we believe that gender neutral decor may be beneficial to all patients by challenging norms that gynecological care is hyperfeminized and
something that should be private, separate and hidden from all other aspects of medical care. Similarly, the decision-making of all patients may benefit from an emphasis on cancer prevention and the pathophysiological importance of cervical cancer screening (Potter et al., 2015), versus perpetuating conceptions that Pap tests are simply something “women have to do.” Furthermore, clinicians should take care to avoid terms of endearment or condescending tones of communication, which any patient might find uncomfortable.

Locus of control in the visit can also be optimized with strict attention to behaviors that patients may perceive as coercive or stigmatizing during both the exam and general patient-provider interaction. Patient counseling can emphasize that the patient has ultimate control over whether to proceed with a Pap test occurs, the role of ongoing consent during the procedure, and that transition-related care will not be affected by decisions about preventive care. If a patient initially declines testing, a provider can respect patient agency and boundaries of comfort by asking permission to revisit the topic at future visits. Assessing comfort with and individual preferences for the exam may increase both the patient’s sense of control and humanization. There are a variety of options providers can offer to address potential sources of patient vulnerability, including nudity, history of trauma and dysphoria (Potter et al., 2015). Providers should avoid reacting to or commenting on any nonrelevant aspect of the patient’s body (i.e. tattoos, changes secondary to hormone use) during the exam and the use of charged, judgmental and/or nonscientific language or comments to prevent any pretense of voyeurism or nonneutral evaluation. Finally, perhaps one of the most important facilitators of patient empowerment and treatment of patient as person is building an empathic and trusting relationship with the provider (von Vogelsang et al., 2016). We agree with Lombardi et al. (2001) that patients may be best served by postponing exams when clinically feasible until such a relationship can be achieved.

Limitations
Our findings must be interpreted in light of some limitations. The lack of racial and class diversity of patient participants may limit generalizability to transmasculine individuals with multiple marginalized identities. As transgender people of color and/or low-income face greater discrimination and lack of access to healthcare (Stroumsa, 2014), research that inadequately addresses the intersectional experiences of transmasculine individuals may perpetuate inequities
among the transmasculine community. Furthermore, our participant demographics raise important questions about which communities have access to and/or are comfortable with Fenway Health services, given that transmasculine participants were recruited primarily through Fenway Health networks and interviews took place at Fenway Health. Online surveys do not allow for the detail and depth of in-person interviews, and some responses were not interpretable without the opportunity for further probing. Our sample of provider participants was small and consisted mostly of Fenway Health employees, though the number of providers who have performed at least one Pap test on a transmasculine individual is likely limited. Furthermore, transgender providers were not represented in this study. The number of “out” providers is also limited, and only one patient participant reported having a transgender provider. Notably, provider focus group participants shared fewer details of internal processes and experiences of emotional vulnerability and discomfort compared to the two in-depth interviews with providers who could not attend the focus group, which limited analysis of the provider perspective. Provider responses may have been skewed towards positive experiences due to pressures of speaking in front of other colleagues. In fact, one of the providers interviewed admitted anonymity enabled them to share honest views of sensitive topics.

**Suggestions for Future Study**

We will next pursue member checking with a community advisory board of transmasculine participants before pursuing broader publication of our findings. Future studies on the experiences of transmasculine individuals of diverse backgrounds are needed to inform the development of evidence-based clinical interventions and guidelines that promote access to affirming cervical cancer screening services for all individuals in the transmasculine community and may identify sources of intra-community disparities. The impact of provider gender on the dynamics of the exam and patient experience deserve further attention. The internal processes that providers engage during the clinical visit that may contribute to disempowering and gender-disaffirming behaviors need to be better understood and may help inform provider education and training efforts. In-depth interviews may be particularly helpful for the collection of richer and more nuanced qualitative data on provider experiences. Development and study of potential patient, provider, and systems-level interventions targeting the barriers to patient-centered gynecological care of transmasculine individuals are also needed. Alternative cervical cancer
screening methods that preclude provider-administered speculum exams, such as patient-collected HPV swabs (McDowell et al., in review), may avoid many aspects of the visit that risk patient disempowerment and disaffirmation, and their effectiveness should be explored. Regardless, the clinical implications outlined herein will remain applicable to the performance of pelvic exams on transmasculine individuals for any indication.

VI. Acknowledgments

We thank the patients and providers who participated in this study for their time and willingness to share their insights and experiences with us. This research was supported by grants from the Harvard gender and Sexuality Caucus, The Harvard Medical School Center for Primary Care and Scholars in Medicine Office.

VII. References


36. Legal L. When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV. New York: Lambda Legal. 2010.


Table 1. Patient sociodemographic characteristics

<table>
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<th>Survey Participants (n=84)</th>
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**Educational attainment***

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**Annual individual income ($)***

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**Gender of Sexual Partners in Last 12 Months**

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* Multiple responses/selections allowed; will not equal 100%.
** Write-in self-descriptions by participants.
*** These data were only collected from in-person interview participants.

Table 2. Healthcare provider sociodemographic and professional characteristics (n=17)
Figure 1. A grounded theory of the interplay of power and gender dynamics in the Gynecological encounter with transmasculine patients.
IX. Appendix

Appendix A. Patient In-Depth Interview guide

Introduction
First I’d like to start off by asking you a little bit about yourself and your health in general.

1. Tell me a little bit about yourself.
   a. What do you do on a typical day?
   b. Who are the most important people in your life?
   c. How would you describe your gender identity?
   d. What has your transition process been like? Where would you describe yourself in the process of transition?
   e. How would you describe your sexual orientation and behavior? How has that changed or remained the same over the course of your transition?

2. Where do you usually get your health care? How would you describe your relationship with this provider?

3. How do you think your gender identity affects your interactions with health care providers?

4. Do you think your race, ethnicity, class, or other aspects of your identity affect your interactions with health care providers – for better or for worse?

5. When you need information about health issues or are making a decision about your health care, who or what do you usually consult for more information? (Probe: friends, health care providers, internet, community organizations, advocacy groups).

6. How easy is it to access information about gynecological care in particular for trans men? What does this information look like?

What do trans men think about Pap tests?
We are conducting this study in order to better understand what trans men’s experiences with Pap tests are like so that eventually we can make this experience better, so we want to hear about all the experiences you’ve had with Paps that you feel comfortable sharing – the good, the bad and the ugly.

1. What do you know about Pap tests?

2. Have you ever talked to your health care provider(s) about cervical cancer or Pap tests?
   a. How did this topic come up? Did someone introduce the topic?
   b. How comfortable did you feel asking your provider any questions you had?

3. Have you ever had a Pap test?

For those who have had a Pap test before:

1. Thinking back to your last Pap test, where did you get the test?
   a. How did you choose this location or provider?
   b. Was the person who performed the test your usual provider?
   c. What types of providers do you like to get your Pap test from? What about that provider made you decide to get a Pap test from them?
   d. Was the test part of a regular annual physical exam or part of a visit for another reason, or did you go specifically to get a Pap?
     i. If for another reason, how did the topic of Paps come up during the visit?
ii. Did you expect to get a Pap test at that visit, or did you make the decision during the visit to get a Pap?

e. What prompted you to get a Pap at that time?

f. How did you receive the results of your Pap?

i. What were the results of your last Pap test and what did you think about them?

ii. What steps did your provider recommend that you take?

iii. How did you proceed?

2. Tell me more about your last Pap test. What was that experience like for you?

a. What was your level of physical comfort or discomfort with the exam?

b. What were your thoughts and emotions before, during, and after the exam?

c. What was your interaction with the doctor like before, during, and after the exam?

d. Have you had any negative experiences in the past that made you more anxious during the Pap? (Probe: trauma history, bad experiences with healthcare system, etc.)

e. What would you have changed about this experience, if possible?

f. Did you disclose or discuss your gender identity with the person who performed the test?

i. Did you feel that having this person be aware of your gender identity affected your treatment, for better or for worse? How?

3. Have you had a test come back as abnormal before? How did you follow up on those results? What was your experience with providers like during follow-up?

4. What was your best experience with a Pap test like?

5. What was your worst experience with a Pap test like? What were some strategies you used to cope (before/during/after)?

6. How has the experience changed or remained the same over the course of transition?

7. When you did get a Pap test, what motivated you to do so?

For participants who have never had a Pap test:

1. What are some of the reasons you haven’t had a Pap test in the past? (Probe: physical discomfort, emotional discomfort, treatment by provider, utility of the test, booking an appointment, provider gender, etc.)

2. Have you discussed any of these concerns with your provider? How did that conversation go?

3. How often does your provider recommend to you to get a Pap test?

4. Have you had any negative experiences in the past that make you less willing to do a Pap test or genital exams more generally? (Probe: trauma history, bad experiences with healthcare system, etc.)

For all participants:

1. How does receiving gynecological care fit or not fit into your gender identity? Are there other medical procedures that bring up similar issues?

2. Have you ever declined to get a Pap test when a doctor suggested you get one? What were your reasons for declining? (Probe: physical discomfort, emotional discomfort, treatment by provider, utility of the test, booking an appointment, provider gender, etc.)

3. How useful do you think the Pap test is in preventing cervical cancer?
4. How confident are you in the results of a Pap test?
5. How often should trans men get tested?
6. Is getting a Pap test more important for some people than others?
7. What might be some reasons why trans men would be reluctant to get a Pap test?
8. What are some reasons that would motivate trans men to have pap tests?
9. What are some things that doctors can do to make trans men in particular feel comfortable during an exam?
10. In your opinion, how could health care providers be more sensitive and attentive to issues of gender identity when providing gynecological care like Pap tests to people like you?

Appendix B. Patient Online Survey

Eligibility Screen:
1. How old are you?
2. Were you born with a cervix?
3. Do you currently identify as a trans man, FTM, on the FTM or transmasculine spectrum, non-binary trans/genderqueer, etc.?

Information Screen:
The purpose of this research study is to learn more about experiences with, perceptions of, and barriers to cervical cancer screening, i.e. Pap tests or Pap smears, among people on the FTM spectrum. This will help us better understand what medical providers can do to make the process better for trans men.

Participation in this study is entirely voluntary. You don’t have to answer every question, and there is space near the end to give us any additional information that you wish we had asked about. We will not collect your name or any directly identifiable information. Unfortunately there is no monetary compensation for participating in this online survey.

The questions presented are taken from the full in-person interview. Please speak with as much detail as possible when you answer a question, since we won’t be able to follow up with you for any additional information. Stories and long thoughts are welcome! We are looking for descriptions of your experiences and opinions, rather than brief factual answers.

When presenting our findings, we may quote what you have told us, but will not identify you (since we don’t know who you are!). If you have any concerns about confidentiality or how we will use this information, please contact transprev@fenwayhealth.org or call 617 927 6412. Feel free to share the link to this interview with others on the FTM spectrum.

Demographics:
1. How do you identify in terms of race/ethnicity?
2. Describe your gender identity and/or transition process.
3. In the past 12 months, what has been the gender(s) of your sexual partner(s), if any?
4. How has your gender identity, race, class, sexuality, or other aspects of your identity affected your relationship with your health care provider(s), for better or for worse?
5. Approximately how many Paps have you had in the past? Please include in this number any times you had your doctor try to give you a Pap, but you were unable to complete the Pap.

For all respondents:

Some open-ended questions follow. Please feel free to respond to those that are most important to your personal experience.

1. Do you think your race, ethnicity, class, gender, or other aspects of your identity affect your interactions with health care providers – for better or for worse? How?
2. What do you know about Pap tests (what is the purpose of the test, what happens during the test, etc)? Where did you get this information? Where can you find specific information available about Paps for people on the FTM spectrum?
3. What motivates you to have Pap tests?
4. What makes you reluctant to have Pap tests?
5. How do Pap tests fit – or not fit – into your gender identity? What gender issues do they bring up for you, if any?
6. In your opinion, how can health care providers be more sensitive to issues of gender identity when providing gynecological care like Pap tests to people like you?
7. If we were to design an outreach campaign (brochures, website, short videos, etc.) to give information about Paps specific to people on the FTM spectrum, what type of information would you include to encourage people to come in for Paps? What type of images or language would you include (or avoid)? Feel free to share what would motivate you personally to come in for Paps, as well as what you think would resonate with the broader community.

If you have had or tried to have a Pap test before, please consider the following questions. If you have never had a Pap test before, please skip to the next section.

1. What have your experiences with Pap tests been like for you? (You might include your level of physical comfort, thoughts or emotions during the exam, your interactions with the doctor, etc.)
2. Did you disclose or discuss your gender identity with the person who performed your last Pap test? Did this affect your treatment-- for better or for worse? How?
3. What was your best experience with a Pap test like? What did you or your provider do to make yourself more comfortable?
4. What was your worst experience with a Pap test like? What were some strategies you used to cope (before/during/after)? How helpful were these strategies?
5. What advice would you give to medical providers about how to make the exam better for patients on the FTM spectrum?
6. Has your experience with Paps or views of Paps changed at all over the course of your social or medical transition? Please explain.
7. Please feel free to share below anything about Paps that you want to talk about, even if we didn’t ask about it specifically:

If you have never had a Pap test done, please consider the questions below.

1. What are some of the reasons you haven’t had a Pap test in the past?
2. Have you had any negative experiences in the past (whether with the medical system or in life more broadly) that make you less willing to do a Pap test or genital exams more generally?

3. Have you discussed any of these concerns with your provider? How did that conversation go?

4. How often does your provider recommend for you to get a Pap test? If they did suggest that you get a Pap test, what made you decline one at the time?

5. Please feel free to share below anything about Paps that you want to talk about, even if we didn’t ask about it specifically:

Appendix C. Provider Focus Group Guide

1. What is the most important piece of advice you would have for a provider performing their first Pap on a trans patient? (ice breaker)

2. Step me through how you perform a Pap visit (or last visit) with trans patients, starting from when the patient walks in the door. What aspects are the same or different from what you would do for a non-trans woman?
   a. What are your interactions with the patient like before, during, and after the exam?
   b. What information is given/terminology is used with the patient?
   c. Describe your technique when performing the exam.
   d. What recommendations do you have for the patient?
   e. What are questions that trans men tend to ask?

3. What are some special considerations you have regarding Pap tests for trans men? Are there other types of patients you would have similar considerations for?

4. It seems like there are many ways a Pap test can be customized to optimize the experience for an individual patient. How do you figure out what works for each patient? What does that process like?

5. How confident/comfortable are you with performing gynecological exams on trans men? How has this changed over time? How did you build your skills?
   a. Can you tell me about a time when you felt anxious or uncomfortable when giving a Pap to a trans patient? How did you manage or cope with your discomfort?
   b. What advice would you give other providers seeking to build these skills? Are there resources out there that give guidance?

6. Have you had a trans male patient who was reluctant to get a test eventually decide to get one? How did you convince them or make them feel comfortable enough to get one?

7. Do you feel there are some trans male patients who will never get a Pap? What do you do for those patients? How do those conversations go?
   a. In cases where Paps were not acceptable to a trans patient, what other tests or exams have you performed, or questions have you asked, to try to assess and manage risk for cervical cancer?

8. Tell me about the best Pap exam you’ve performed on a trans man. What was good about it? What made it go so well?
9. Tell me about the worst Pap exam you’ve performed on a trans man. What was bad about it? What went wrong?
10. How do you think trans men tend to view or approach Pap tests, in comparison to how non-transgender women approach the exam? What are the similarities and differences?
11. Are there subgroups of trans men who have an easier or more difficult time with Pap tests? (Probe: social and medical transition status, trauma history, sociodemographics, sexual orientation, sexual behaviors)
   a. How are these patterns the same or different in non-trans women?
12. Do you feel the average trans man is more, equally, or less at risk for cervical cancer than the average non-transgender woman? Why?
   a. How do you assess risk for cervical cancer in trans men? How is your assessment of risk the same or different than in non-transgender women?
13. When a Pap result requires additional follow up – say an inadequate sample or one with low-level changes – do you interpret those results any differently for trans men on T?
   a. What do you think causes higher rates of inadequate samples with trans men?
   b. Is there anything providers can do to increase the chances of getting a better sample?
14. A minority of trans patients we have interviewed report experiencing extreme pain during the Pap test. What do you think might be the cause of this pain?
15. What are some strategies you use, if any, for presenting the Pap test as a male or gender-neutral procedure?