I am a gynecologic health provider. The abhorrent, repetitive, and years-long sexual assaults of Larry Nassar (Schuman, 2017), seemingly in the name of health care, threaten the work of my profession. Not only did countless individuals in authority ignore the reports of students and athletes, not only did those same individuals trust in a health care provider so deeply as not to consider his work in the realm of assault, but the profession of gynecologic providers stayed silent. I will not. Above all else, the incredible voices and strength of those who came forward to report his crimes, and those in community with them but who were unable to speak, bring me a bonfire of passion to speak out, and intentionally practice and teach empowering, consensual, and evidence-based pelvic care.

One in five women will be assaulted in their lifetime (National Sexual Violence Resource Center, 2015), and the numbers are higher for queer and trans individuals (Human Rights Campaign, n.d.), and again higher for individuals of color (Meyerson, 2017). Sexual assault coverage currently dominates mainstream media with the #MeToo and #TimesUp campaigns, and Time magazine naming the collective group of individuals coming forward as the 2017 Person of the Year (Zacharek, Dockterman, & Sweetland Edwards, 2017). These movements have encouraged survivors to name assailants from years or decades prior, speaking to the fact that women and trans individuals have not been safe in their lives and bodies for a long time. Some of the most well-known and previously respected film figures are now publicly shamed for their crimes against individuals’ bodies from decades ago (Digh, 2017). However, those speaking out continue to risk persecution, and we watch known attackers experience no recourse. The anonymous creator of the “Sh*tty Men in Media” list, made to protect colleagues in the workplace, was forced to name herself and now fears for her safety and livelihood (Donegan, 2018). The anonymous report of Aziz Ansari’s sexual aggression somehow has now led to people calling the question of whether women coming forward have somehow gone too far (Gray, 2018), as if going too far is a possibility when the highest ranking elected official in our country is a bragging sexual assailant (Bush, 2017).

Further, assaults on women and trans individuals’ bodies in the name of health care is, horrifyingly, not new. When abortion was illegal, women reported sexual abuse by the provider (Grimes, 2015): this was an understood risk of seeking critical but clandestine services. The history of unconsented sterilization (Ko, 2016) against women of color is so well-established there are now legal stop-gaps to prevent its recurrence. Medical students continue to write about performing pelvic and bimanual examinations on women under anesthesia for non-pelvic procedures (Barnes, 2012), without their explicit consent. pregnant women have been forced into continuing pregnancies they do not want (Valenti, 2017), or undergoing cesarean sections against their will (Redden, 2017). A woman who declined an episiotomy during labor was subsequently cut 12 times by her male physician (Grant, 2017). Larry Nassar is yet another example.

In considering Nassar’s circumstances, the opportunity for unchecked and unquestioned assault was multifactorial: patients, by labeling, are at a decreased power level to their providers; women, by existence, are at a decreased power level to men; and students and ath-
All health care providers should deeply evaluate their consent process and disentangle, to every extent possible, sexualized language or touch from clinical care.

health care and sex too uncomfortable to truly be addressed? Nassar's sexual assaults cannot be said in the same breath as health care. But health care providers must acknowledge that his actions exist in the context of historic and current abuses of gynecology. I believe the general silence from gynecologic providers speaks volumes to the profession’s intentionality to disentangle the nature and then on the outside”), check in throughout the procedure (e.g., “Tell me if you’re feeling any pain”), and then afterward (e.g., “Tell me if there’s anything I can do next time to make that exam more comfortable”). I have written before about the importance of providers making space for transferring power during care (Feminist Midwife, 2014), and strategies to do so in pelvic care specifically (Feminist

Midwife, 2016). Luckily, many in my profession continue to question the need to enter individuals’ bodies for pelvic care (Crawford, 2017), carefully considering recommendations for when to do so.

I experience myriad emotional, physical, and intellectual reactions when discussing pelvic examinations. As a patient who has had good and bad pelvic examinations. As a survivor of sexual assault. As someone who exists in a world where my body is always, seemingly, available for assault. As a queer person for whom a digital examination mirrors sexual intimacy. And now as a clinician. All these factors lead me to question my profession's overlap with conversations around sexual assault: How many students in health care professions have witnessed an attending clinician inappropriately examine a patient? How are providers being taught consent, power transfer, and ensuring patients know their rights? How do clinicians practice trauma-informed care knowing that their work parallels individuals’ intimate lives or history of assault? How can patients have space to question what happened during an examination, and feel safe doing so? How can all individuals be given language to challenge the medical model when something goes terribly wrong? And how do all clinicians really talk about Nassar's impact on pelvic health care?

Now in my sixth year of gynecologic practice, I believe more than ever that the most important knowledge base is the individual whose pelvis needs care. And in my 34th year of being alive, I believe that women should be trusted and believed when they say something happened to them. Clinical care is currently organized and reinforced as a model where the provider holds power: this hierarchy must continue to be challenged and changed. Evidence-based, consensual, and empowering pelvic care must be a space where individuals feel safe to own their bodies, ask questions, and receive true care.


Guest Editorial
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