Female Genital Cutting

To the Editor:

Female genital cutting (FGC) is unethical. It causes physical, psychological, and emotional harm, and is rarely performed with consent. SOGC Clinical Practice Guideline no. 299 on FGC outlines this argument well.[1] However, re-infibulation is inappropriately bundled together with FGC. Re-infibulation is fundamentally different, surgically and ethically, from FGC. The two need to be examined independently, particularly since the guideline prohibits re-infibulation.

Infibulation is excision of the labia minora, usually with the clitoris, followed by closure of the vulvar opening. Usually performed on girls without consent, it is mutilating, painful, and dangerous. Once the initial injury has healed, obstruction of the vulvar opening can lead to chronic urinary tract infection and dyspareunia. The practice is unethical from the perspectives of beneficence, non-maleficence, and autonomy. Even if an informed, competent adult woman requested FGC, the ethical principles of beneficence and non-maleficence would overrule autonomy.

De-infibulation and re-infibulation are different from infibulation. With time and sexual intercourse, the membrane covering the vulvar opening usually becomes pliant enough to allow pain-free intercourse and free passage of urine. During childbirth, however, the membrane can impede vaginal delivery and increase the risk of anal sphincter injury. De-infibulation involves incision of the anterior membrane while protecting the urethral meatus. It can be medically indicated to facilitate vaginal delivery and protect the anal sphincter, or it can occur spontaneously during delivery (tearing). After incision or tearing, the lacerated edges of remnants of labia minora can be left to form small labia minora or sutured together to reform the membrane, which constitutes re-infibulation.

FGC is "all procedures involving partial or total removal of the external female genitalia or other injury to the female organs for non-medical reasons." De-infibulation and episiotomy—cutting genital tissue *for medical indication*—are not FGC. Re-infibulation is analogous to repairing an episiotomy; it does not involve injury, cutting, or removal of genital tissue, and therefore is not FGC.

Although re-infibulation is often surgically benign, banning it can cause harm. For example, a woman with a history of FGC was advised by an obstetrician that re-infibulation would not be done after delivery. She felt offended and did not return for prenatal care. An avoidable perinatal death resulted. Another woman with a history of FGC requested primary Caesarean section because she was told that re-infibulation could not be performed in Canada. An obstetrician performed a primary Caesarean section on maternal request. The woman experienced a wound infection.

Women who have experienced FGC have universally undergone trauma. However, what is done is done. Despite physical, psychological, and emotional scars, for many of these women their anatomy has become part of their identity and is personally and culturally important to them. Surgically, re-infibulation is no more invasive than repairing a labial tear. A woman without complications from her vestibular membrane before delivery is unlikely to develop them once re-infibulated, and there is no medical contraindication to re-infibulation.

The SOGC Guideline states that "Requests for re-infibulation must be denied . . . because [re-infibulation] may legitimize the practice of FGC/M in general." There is no evidence to support this statement. The referenced WHO document suggests re-infibulation "should be prevented [because it] recreates the same problems of gynaecological, sexual and reproductive health, including difficulties associated with childbirth and the need for further surgeries that the original infibulation had created."[2] This is not the case for many women. Furthermore, the WHO document does not advise that re-infibulation should be prohibited, rather that women should be counselled against it.[2]

The goal of eradicating FGC is laudable and pressing, but there is no evidence that allowing re-infibulation will interfere with that goal. Sensitive counselling against re-infibulation may be prudent; however, once a woman has been counselled, her choice should be respected. Honouring a request for re-infibulation respects a woman's autonomy and cultural identity and prevents emotional, psychological, and potentially physical harm. If a clinician believes the surgical repair is medically contraindicated (e.g., in a woman with a history of chronic urinary tract infections), then a request for re-infibulation may be denied on medical grounds. Otherwise, denying requests for re-infibulation is paternalistic, disrespectful of women's autonomy, and not "culturally competent" care. Such denial contributes to harm that the Guideline expressly hopes to avoid: women's perceptions that "they were treated in ways that they perceived harsh and even offensive to [their]

cultural values," and "deter[ring] women with FGC and their families from seeking care until absolutely necessary,"[1] or worse, until harm has been done.

Culturally competent care does not mean relaxing standards to accede to the customs of other cultures. It does, however, mean treating women in as culturally sensitive a fashion as possible within the constraints of accepted ethical principles and sound medical practice. Re-infibulation for women who request it and in whom it is deemed surgically safe is culturally sensitive, respectful of autonomy, and ethically sound.

Re-infibulation is not FGC and should not be grouped with FGC. Refusing re-infibulation can cause significant harm. If it is considered medically safe, patient autonomy and cultural competency mandate that a request for re-infibulation be respected. SOGC Clinical Practice Guideline No. 299 should be altered accordingly.

Clinical case details have been altered to protect patient confidentiality.

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J Obstet Gynaecol Can 2014;36(8):671–672

In Response

To the Editor:

Dr Kotaska and Dr Avery raise many of the issues that have fuelled recent debate on the role of choice, and the proper role of physicians, with respect to re-infibulation. The SOGC remains opposed to female genital cutting, both the initial cutting and possible re-infibulation. In this we are aligned with the World Health Organization, the International Federation of Gynecology and Obstetrics, and United Nations organizations (such as UNDP, UNFPA, UNICEF and UNIFEM) that collaborated in a landmark policy document on the role of health care providers in eliminating female genital cutting/mutilation (FGC/M).

Our policy statement published in February 2012,[1] which remains in effect, is very clear in asserting that "performing or assisting with the practice of FGC/M in Canada is a criminal offence" and that "requests" for re-infibulation must be declined.

The Female Genital Cutting Clinical Practice Guideline published in November 2013[2] focuses on the provision of respectful and culturally competent reproductive health care for women who have undergone FGC. The document provides guidance for health care workers on the provision of obstetrical care for these women, including the repair of perineal damage following a vaginal birth (in the "Obstetrical Care" section of the guideline).

In no way does the SOGC suggest there is a window for accepting re-infibulation, and we are of the opinion that compliance with such a request, however well intended, contributes to the perpetuation of the practice. The SOCG stands by its policy statement and its commitment to eradicate the practice of female genital mutilation.

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J Obstet Gynaecol Can 2014;36(8):672

The Physician as Eavesdropper: Interdisciplinary Communication in the Operating Room

To the Editor:

As the Royal College gears up for the release of the 2015 update to the CanMEDS roles,[1] I have been thinking about a competency that we rely on far too often—the physician as eavesdropper. Anaesthetists are our unsung heroes, but our