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.

Andrew Kotaska, MD, FRCSC
Department of Obstetrics,
Stanton Territorial Hospital, Yellowknife NT
Lisa Avery, MD, MIH, FRCSC
Centre for Global Public Health,
University of Manitoba, Winnipeg MB
Departments of Community Health Sciences and Obstetrics,
Gynecology and Reproductive Sciences,
University of Manitoba, Winnipeg MB

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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.

Jennifer Blake, MD, MSc, FRCSC
Chief Executive Officer, The Society of Obstetricians
and Gynaecologists of Canada, Ottawa ON

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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