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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REFERENCES

1. Perron L, Senikas V. Burnett M, Davis V; SOGC Social Sexual Issues Committee; SOGC Ethics Committee. Female genital cutting. SOGC Clinical Practice Guideline No. 299, November 2013. J Obstet Gynaecol Can 2013;35(11):e1–e18.
2. UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, et al. Global strategy to stop health care providers from performing female genital mutilation. Geneva: World Health Organization; 2010. Available at: http://www.who.int/reproductivehealth/ publications/fgm/rhr_10_9/en/ index.html. Accessed March 7, 2014.

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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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REFERENCES

1. Perron L, Senikas V. Female genital cutting/mutilation. SOGC Policy Statement No. 272, February 2012. J Obstet Gynaecol Can 2013;34(2):197–200.
2. Perron L, Senikas V, Burnett M, Davis V; SOGC Social Sexual Issues Committee; SOGC Ethics Committee. Female genital cutting. SOGC Clinical Practice Guideline No. 299, November 2013. J Obstet Gynaecol Can 2013;35(11):e1–e18.

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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

colleagues on the other side of the sterile drape have learned to glean, assume, suspect, infer, and guess at what's going on during the surgery from sounds and muttered phrases coming from our side. As a simulation educator who is fortunate enough to have facilitated and debriefed numerous scenarios each year over the last decade, I have probably learned more about interprofessional and interdisciplinary communication than any of my students. I preach that in medicine, and in fact in most facets of life, "communication fixes everything." We teach our residents to hand over information during a crisis with military efficiency. We teach them to use closed-loop communication when issuing orders to allied health personnel. We teach them to verbalize their plans so that everyone in the room is on the same page. But when we become stressed in the operating room, we know that the anaesthetists with whom we are most comfortable working are the ones who can seemingly read our mind. They have mastered the art of listening to the suction in order to gauge blood loss. They have learned to ask for carbetocin when they hear us talk about the boggy uterus. They call the blood bank when we wonder aloud who the "second on-call" is. They are good at bailing us out, but I think they deserve better.

The last few years have seen a flurry of attention paid to improved patient safety through interprofessional and interdisciplinary team training. The surgical checklist and preoperative pause are examples of interventions aimed at improving patient safety.[2] However, I think the more important potential outcome of these interventions is an improved culture in the operating room, in which the surgery begins only once everyone in the room has the same perspective on what's about to transpire. Irrespective of the recent high-profile publication that called the utility of the checklist into question,[3] anything that chips away at the hierarchy in the operating room and improves sharing of information is a step in the right direction. I would like to see this explicit sharing of information continue throughout the operation, and as we surgeons become better masters of "communicator" and "collaborator" competencies, the anaesthetists can let their eavesdropping skills wane. We know that superlative communication skills are appreciated by patients and can sometimes moderate malpractice claims.[4] My anaesthetist friends tell me that they also appreciate a communicative surgeon with good insight who stays out of trouble. Let's endeavour to be the kind of surgeons that anaesthetists want to work with; better communication may not fix everything, but it never hurts.

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REFERENCES

1. Frank JR, Snell L. Draft CanMEDS 2015 Physician Competency Framework—Series I. Ottawa: The Royal College of Physicians and Surgeons of Canada; 2014 Feb.
2. Haynes AB, Weiser TG, Berry WR, Lipsita SR, Breizat AH, Dellinger EP, et al. for the Safe Surgery Saves Lives Study Group. A surgical safety checklist to reduce morbidity and mortality in a global population. N Engl J Med 2009; 360:491–9.
3. Urbach DR, Govindarajan A, Saskin R, Wilton AS, Baxter NN. Introduction of surgical safety checklists in Ontario, Canada. N Engl J Med 2014;370:1029–38.
4. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. JAMA 1997;277:553–9.

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