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Reflective Practice

‘Gosh’: A cross-cultural encounter with a Somali woman, a male interpreter and a gynecologist on female genital cutting/mutilation☆

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I saw the woman for the first time on the gynecological emergency at a Swiss University Women’s Hospital. She was referred for assessment of lower abdominal pain, which turned out to be a ‘cover-up’ for the subsequent case presentation. The 22-years old, married woman had a low proficiency in English and none in German, and was an asylum seeker from Somalia. The history and clinical examination for lower abdominal pain revealed no pathological results – but her female external genitalia presented an unforgettable finding I had never seen before during my clinical career in Switzerland and also in Cameroon. The vagina was closed except for a small opening with a diameter like a little finger. The scar was vertically interspersed with various horizontal skin fissures and scar tissues.

When discussing the topic in theory like with other clinicians, I always promoted the term Female Genital *Cutting*, FGC, instead of the more value-loaded term Female Genital *Mutilation*, FGM, which emphasizes the notion of a harmful practice. But now, the finding of this gynecological examination was showing the extreme of the practice in all its harm just in front of my eyes – having nothing in common with the illustrations known from publications – leaving me puzzled and uncertain in diagnosing the condition sufficiently. At this very moment the woman was reduced to her ‘mutilated’ genitals and its visual image provoked disparate responses [1]. I was at once, an individual looking at this mutilated sexual organ with a mix of *subjective* feelings and a clinician making an assessment by collecting *objective*, medical facts of her genitals. This finding turned FGC to FGM in my view and made me start using the term FGC/M since then.

We made an appointment for another visit at the outpatient clinic with a female friend whom she explicitly wished for translation. But she showed up alone again and a phone call revealed her friends’ low English proficiency. This time a detailed exploration of the genital condition by a senior and experienced gynecological surgeon took place accompanied by questions such as if the infibulation scar impedes the flow of her urine, which she affirmed. She said she had one painful, sexual intercourse with her husband and that she wants an opening of the scar, a so-called defibulation. Her husband seemed supportive of the decision to undergo the procedure.

To prepare for the next steps an additional visit with a female professional interpreter was organized. But the hospitals collaborating interpreter service had only one Somali interpreter on their team – a man. This created a critical situation against *best practice*; encounters dealing with sexuality and reproductive health issues like the practice of FGC/M, are closely related to the female sphere and can be aggravated by the issue of shame in a gender discordant setting [2]. I was aware that this situation was fraught with problems, but it did not make sense to go ahead without addressing the language barrier properly to give her full and clear information about the procedure and the physical changes resulting from it. In addition, the male interpreter was already in front of the consultation room. I decided to have a try but would the woman agree? After a moment’s hesitation she agreed. She was informed of the medical interpreters’ commitment to confidentiality and privacy. We further clarified possible helpful arrangements to facilitate the conversation with the three of us. For example, she wished no drawing of the vagina – which forms part of the informed consent for an operation – in front of the interpreter. A preliminary talk took place as well with the interpreter himself to inform him about the agreements made and to learn about his considerations to smooth the situation.

When the time came for the encounter the three of us were sitting together, myself behind the desk, the interpreter sat across at one end of the table leaning against the wall, and the woman at the further end on the edge. By her backing away, the way she kept looking to the floor and smiling ‘shyly’ indicated to me that she was

☆ For more information on the Reflective Practice section please see: Hatem D, Rider EA. Sharing stories: narrative medicine in an evidence-based world. Patient Education and Counseling 2004;54:251–253.

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uncomfortable. I felt tensed and worried if I would be able to adequately tackle this situation. Despite having additional background in counseling techniques and medical anthropology, in this very moment I felt like I was entering 'unknown territory' when looking for an appropriate way to transfer theory into clinical practice on a fraught subject within rather unfavorable conditions.

I decided to address first the unusual and precarious context of our consultation. I 'blamed myself' in case anything goes 'wrong' hoping it would relieve them by letting them off the hook. At the same time, the idea rushed to my mind that this is probably quite the contrary of what she or he may expect of a physician to behave. Then I took up her desire for becoming pregnant to provide her information on the reproductive cycle and female genitals with the idea to start with a more neutral subject as a 'warm-up' before progressing to more intimate issues. At the same time, I provided useful information in appropriate wording and in a culturally sensitive manner, partly shaped by my previous work experience in Cameroon. For example, I noticed how I immediately reverted to paraphrasing sexual intercourse or explaining the reproductive organs and their functioning in the way I adopted during my work at a gynecological department in Cameroon. Furthermore, I maneuvered gently around social norms restricting an open exchange on reproductive and sexual matters among women and men, and notions of gender roles. This seemed to work out well in light of a rather lively conversation and the types of questions she asked.

Then we turned to her history of FGC/M and related physical symptoms. This was going well except in the following situations. When she reported being excised in her village at the age of 7, the question of the circumciser's 'qualification' came up having the visual aspect of her genitals in my mind. Suddenly, a brief autonomous dialog arose in between the interpreter and the woman. Upon request he explained when she responded to my question with ''No, no, they are good'', he replied to her that she knows this is not true. Another limitation appeared when she stated again that she already had sexual intercourse with her husband. Even while a vaginal penetration was rather unlikely according to our genital findings I abstained from exploring it further fearing this would be too intimate and offensive in this gender discordant setting. Finally, we talked about the operation itself. According to the agreements made beforehand the interpreter left the room now and I explained the operation to her alone by using photographs and drawing the steps to be taken assisted by gestures. Then I invited the interpreter back in the room, and re-explained the operation along with possible medical complications and the postoperative procedure but without using any pictorial material.

Altogether, the consultation seemingly turned out well and the tense atmosphere gave way to a more cheerful mood of joking and laughing, which helped to cope with this complex situation. The operation was without any complications and a few months later the woman was pregnant. For myself, the 'gosh' fueled by my initial bewilderment confronted by a rare clinical case combined with a complex cross-cultural encounter finally led to gratification. In retrospect, the subsequent engagement with this encounter and chosen approach were extremely helpful and instructive. Theoretical knowledge of female genital cutting/mutilation and cultural competent care was applied in practice and became a tangible reality in which skills of cultural competence (e.g., self-reflection, background information and experience) revealed their potential as useful tools in a convincing manner.

Statement

I confirm all patient identifiers have been removed or disguised so the patient described are not identifiable and cannot be identified through details of the story.

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