

Developing Physician Educational Competencies for the Management of Female Genital Cutting: A Call to Action

Holly G. Atkinson, MD, FACP and Amaris Geisler, BS

Abstract

Female genital cutting (FGC), also called female genital mutilation, is defined as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious, or other nontherapeutic reasons.” FGC can have significant health consequences, including multiple physical and psychological complications, throughout the life course. Despite violating numerous human rights and existing legal prohibitions, the practice continues. In the United States, FGC is becoming increasingly prevalent, however, physicians are not routinely trained to care for these patients. Despite the evidence of the need, there is a woeful lack of training regarding FGC in undergraduate, graduate, and continuing medical education programs. Furthermore, many health care providers (HCPs) are unaware of their mandatory reporting obligations regarding FGC under current state laws. There are no established educational competencies or training guidelines for incorporating FGC into all levels of medical education. This article establishes the need to develop competencies and underscores that models exist for undertaking this work. It also aims to engender dialog about FGC education and calls for launching an initiative to develop educational competencies to train HCPs about FGC. By integrating comprehensive, evidence-based education and training at all levels of medical education, HCPs will be able to provide high-quality, team-based, culturally sensitive care to the hundreds of thousands of affected women and girls in the United States, and work to prevent the practice from being carried out on girls who are at risk but have not yet been cut.

Keywords: female genital cutting, female genital mutilation, medical education, competency development

A Violation of Human Rights

IN 1997, THE WORLD HEALTH ORGANIZATION (WHO), in conjunction with the United Nations Children's Emergency Fund and United Nations Population Fund, defined Female Genital Cutting (FGC) (also called female genital mutilation or circumcision) as, “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious, or other nontherapeutic reasons.”¹

WHO has delineated four types: (Type I) clitoridectomy—partial or total removal of the external clitoris; (Type II) excision—partial or total removal of the external clitoris and labia minora; (Type III) infibulation—cutting and repositioning the labia minora or labia majora to form a covering seal, narrowing the vaginal opening; and (Type IV) all other harmful procedures to the female genitalia for non-medical purposes, including, but not limited to, pricking,

piercing, incising, scraping, and cauterizing the genital area.² Type III often requires deinfibulation (cutting open the narrowed introitus) to allow for intercourse and/or childbirth and is also recommended for treatment of various conditions, such as severe dysmenorrhea, urinary outflow obstruction, and recurrent urinary tract infections, as well as in young children who are newly infibulated.

FGC is considered a violation of numerous human rights that are enshrined in various human rights documents, including the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child.³ FGC violates women and girls' right to health, security, and freedom from violence, physical integrity, and the freedom from torture, cruelty, and inhuman or degrading treatment. The procedure, which is typically performed on minors who are a few months to 15 years of age, also violates numerous rights of the girl child. When it results in death,

FGC violates the right to life. In addition, numerous African nations and industrialized nations, including the United States (US), have enacted laws against the practice, and yet despite legal prohibitions, the cultural practice continues.⁴

A Widespread Practice

Globally, an estimated 3 million girls are at risk annually for undergoing genital cutting and ~200 million women and girls have already experienced FGC.² It is most prevalent in about 30 countries in Africa, however, it is also practiced in the Middle East and in Asia, including in Bangladesh, India, Indonesia, Iran, Malaysia, Pakistan, Russia, Singapore, Sri Lanka, and Thailand. With the extensive migration of FGC-practicing groups, developed nations are increasingly hosting communities of women and girls who have undergone the procedure.

Experts have estimated that ~513,000 women and girls living in the United States have already undergone FGC or are at risk of undergoing cutting,⁵ a substantial upward re-adjustment of the 2000 estimate of 228,000.⁶ The current figure was derived from applying the country-specific prevalence of FGC to the estimated number of women and girls living in the United States who either were born in that country or who lived with a parent born in that country.

It should be noted that this estimate is imprecise for several reasons, among them: it uses national prevalence statistics and applies them to migrants, who are a unique segment of a country's population; and it conflates women and girls who may already have been cut and are thus no longer at risk with girls who were born to women from FGC-practicing countries and may be at risk of being cut. These two populations have different needs: the first needs improved care, whereas the second may require protection. Other researchers have suggested an improved method of indirect estimation of the prevalence of FGC among first-generation migrants based on the migrants' selection hypothesis used to correct national prevalence estimates.⁷

Nevertheless, as affected immigrant populations increase in the United States, more physicians, nurses, midwives, physician assistants, and nurse practitioners, among others health care providers (HCPs), whether they are aware of it or not, will be caring for women and girls with FGC. HCPs in internal medicine, family medicine, pediatrics, OBGYN, and psychological services, especially in large, urban, inner cities, are likely to encounter women and girls who have undergone FGC (Table 1). This is especially true for HCPs in urban centers that are home to large immigrant communities from FGC-practicing countries.

While the American College of Obstetricians and Gynecologist developed an educational program in 1999 and updated it in 2008,⁸ and there have been calls in the medical literature to enhance educational initiatives,^{9–12} there is still a woeful lack of education regarding FGC in both undergraduate and graduate medical education programs across the United States. Although data are somewhat limited, evidence suggests that American HCPs are not sufficiently prepared to provide comprehensive, culturally sensitive care to women and girls affected by FGC.^{13–16}

A 2010 survey of certified nurse-midwives revealed that while many of the respondents knew physical and medical facts about FGC, they lacked knowledge on the legal and

TABLE 1. U.S. WOMEN AND GIRLS POTENTIALLY AT RISK FOR FGM/C, BY METRO AREA, 2013

Top 10 metro areas	No. of women and girls
1. New York–Newark–Jersey City, NY-NJ-PA	65,893
2. Washington–Arlington–Alexandria, DC-VA-MD-WV	51,411
3. Minneapolis–St. Paul–Bloomington, MN-WI	37,417
4. Los Angeles–Long Beach–Anaheim, CA	23,216
5. Seattle–Tacoma–Bellevue, WA	22,923
6. Atlanta–Sandy Springs–Roswell, GA	19,075
7. Columbus, OH	18,154
8. Philadelphia–Camden–Wilmington, PA-NJ-DE-MD	16,417
9. Dallas–Fort Worth–Arlington, TX	15,854
10. Boston–Cambridge–Newton, MA-NH	11,347

Source: Population Reference Bureau. Estimates are subject to both sampling and nonsampling error.

cultural aspects that are important when providing culturally competent care. The researchers reported that only 18% of respondents knew that both Muslim and Christian women may be circumcised and just 39% knew that neither religion requires women to be cut. About 56% of respondents knew that it is against the law in the United States for minors to undergo FGC and fewer than 50% of respondents knew that women with FGC in the United States avoid health care because of fear related to legal issues regarding FGC.¹⁷

The findings of a 2017 online survey of 288 American obstetricians/gynecologist conducted by Moaddab and colleagues revealed that while almost 60% of them said that they had seen patients who had undergone FGC, 80% of these physicians reported that their institutions had no policies or guidelines for management and only 56.7% of them were aware that federal law prohibits the practice.¹⁸ Currently, there are no published studies specifically involving U.S. practicing family physicians or pediatricians on their knowledge, attitudes, and practices regarding FGC.

A 2018 study by Johansen et al. mapped the involvement of the health sector in the management of FGC, including whether or not systematic training occurred, across 30 countries where FGC is either a traditional practice or practiced mainly by migrant populations in host countries. The study findings revealed that training in the United States is *ad hoc*.¹⁹

We hope this Commentary engenders further dialog around the need to address the gap in FGC education and training, and specifically facilitates the development of competency lists* for a number of disciplines, including medicine, nursing, and mental health. Ultimately, quality care for women and girls with FGC cannot be provided without a team-based approach, and thus, several disciplines have important work to do on this issue. This Commentary provides a specific strategy for the field of medicine to develop competencies for physicians, although we anticipate collaboration with other professional

* A *competency list* is defined as, “the delineation of the specific competencies within a competency framework.” *Domains of competency* are defined as, “broad distinguishable areas of competence that in the aggregate constitute a general descriptive framework for a profession.” From Englander et al.⁴¹

organizations to ensure that entire teams, not just physicians, are able to provide quality care.

The Need for Comprehensive Medical Education

Education and training about FGC should be incorporated into American medical education programs, both at undergraduate and graduate levels, as well as offered as part of continuing medical education initiatives, to close the gap in knowledge and ensure both recognition of and culturally informed treatment of FGC-related issues and complications. Numerous studies have documented the physical and psychological complications of FGC. It is important to note that medical complications are not confined to the adult; there are both immediate medical complications in girls and long-term complications that manifest in girls and teens. FGC is, at its core, a cultural practice aimed at infants and prepubescent girls, and thus needs to be recognized as a pediatric practice.

Short-term complications include hemorrhage, shock, and infection leading to septicemia, which are the primary causes of mortality.¹⁰ Long-term complications include dysmenorrhea; chronic pelvic infections; urinary tract infections; kidney stones; keloid, sebaceous cyst, and neuroma formation; and the development of fistula.¹⁰ Studies also have documented obstetrical complications, especially in women who have Type III FGC, including an increased incidence of cesarean section, postpartum hemorrhage, perineal tears and wound infections, prolonged second stage of labor, separation of episiotomy scars, extended maternal hospital stays, and sepsis.¹⁰ Women who have undergone FGC also have demonstrated high rates of mental health disorders, including post-traumatic stress disorder, anxiety, and depression.^{20–23}

Sexual functioning can be affected as well, with studies showing FGC is linked to clinically significant and distressing problems with all three phases of the sexual response cycle—desire, arousal/excitement, and orgasm.²⁴ Studies have shown, for example, that FGC-affected women have reported higher rates of lack of sexual desire,²⁵ dyspareunia,^{26,27} decreased orgasmic functioning,^{28,29} and less sexual satisfaction^{29,30} than women who have not been cut. However, it is important to note that women with FGC have sexual erectile tissues for sexual arousal and orgasm,²⁷ and some can and do experience pleasure and orgasm and report satisfying sexual lives.²⁸ A complex interplay of numerous physiological, psychological, and societal factors influence FGC-affected women's sexuality. Migration to Western countries—where FGC is highly stigmatized and discourse is around categorizing them as “mutilated” and “sexually disfigured”—can undermine affected women and girls' body image, self-esteem, and sense of femininity, and thereby contribute to the risk of sexual dysfunction when living in host communities.^{31–33}

HCPs' attitudes are also known to affect women's experiences of childbirth in host countries. For example, a qualitative metasynthesis of the labor and birth experiences of immigrant women in countries of resettlement who had a history of FGC revealed that birth in this context included pain and anxiety and had the potential to retraumatize.³⁴ Women reported that fear and anxiety about inappropriate clinical management often characterized their encounters with HCPs.³⁴

Many HCPs are unaware of their obligations regarding FGC under the law. In 1996, Congress passed the *Federal*

Prohibition of Female Genital Mutilation Act that made it illegal to perform FGC on anyone under the age of 18 in the United States.³⁵ In 2013 that act was amended with the *Transport for Female Genital Mutilation Act*, which criminalizes knowingly transporting a girl under age 18 out of the United States for the purpose of undergoing FGC (known as “vacation cutting”).³⁶ As of October 2018, 27 states have passed laws specifically against FGC.³⁷ Statutes vary regarding the issues that are addressed, for example, the length of the prison sentence; whether parents/guardians and circumcisers are subject to prosecution; whether travel outside the United States for cutting is banned; and whether there are provisions for community education and outreach, among others.

Only 6 of the 27 states have educational provisions, which are very broadly construed and tend to focus on communities that have historically practiced FGC, although three states stipulate that the medical community should be included in educational outreach efforts as well.³⁷ States that do not have specific FGC laws may use other general statutes, such as assault, battery, or child abuse laws to address FGC. Physicians, as mandatory reporters, are obligated to report suspected or completed cases of FGC performed in the United States, as well as report cases suspected as having occurred as a consequence of vacation cutting or of anticipated transportation of minors to undergo the procedure abroad.

With the first arrests in the United States of physicians accused of performing FGC, education and training about FGC has become even more crucial. In April 2017, two Michigan physicians of the Indian Dawoodi Bohra community were charged with performing FGC on upward of 100 minor girls, some of whom had traveled interstate with their parents to have the procedure performed.³⁸ The outcome of this case promises to be disruptive to American medical ethics regardless of how it is ultimately decided. Current ethical dilemmas—for example, the question of performing “ritual nicks” or other “*de minimis*” Type IV FGC procedures to satisfy cultural and religious demands for female circumcision, the difference between culturally accepted cosmetic labiaplasty and broadly condemned FGC, and the widespread acceptance of male circumcision versus the prohibition against female circumcision—may intensify.

Physicians and other HCPs need information regarding mandatory reporting laws, as well as guidance in grappling with the challenging, complex ethical issues raised by the practice of FGC. They also need training regarding culturally sensitive approaches to communication with FGC patients. Numerous episodes, in which patients have been traumatized after experiencing inappropriate comments, humiliating examinations, and sometimes insufficient care by HCPs unprepared to manage FGC, have been documented.^{39,40} Finally, physicians and other HCPs need training in best practices regarding the prevention of FGC both in terms of identifying at-risk girls and communicating with their families, as well as how to engage more broadly with practicing communities to work toward eradicating FGC.

Models for Developing Educational Competencies

Competencies for the comprehensive management of FGC for health profession learners at all levels of training—undergraduate, graduate, and continuing medical education—

TABLE 2. DOMAINS FOR GENERAL PHYSICIAN COMPETENCIES

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1. Patient care
 2. Knowledge for practice
 3. Practice-based learning and improvement
 4. Interpersonal and communication skills
 5. Professionalism
 6. Systems-based practice
 7. Interprofessional collaboration
 8. Personal and professional development
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Source: Englander et al.⁴¹

and all specialties have not yet been established. Key stakeholders, including clinicians, medical educators, researchers, and public health experts, should work together to create a professional competency list in various domains of competencies to improve health care for girls and women who have undergone FGC. This gap need not be addressed simply as an “add-on,” rather it can be addressed within the larger context of recently codified physician competencies. Englander et al., having responded to the need for a “master” taxonomy, or classification structure, for use at the Association of American Medical Colleges (AAMC), conducted a systematic review and analysis of over 150 published competency frameworks for physicians and other health professionals across countries, specialties, and the continuum of education and training. As a result, they proposed a more comprehensive standardized list of physician competencies, called the Physician Competency Reference Set (PCRS),⁴¹ consisting of 58 competencies categorized into eight domains (Table 2).

Eckstrand et al. have pointed out that the PCRS framework is not content or population specific, rather the listed competencies are abstract.⁴² They present a model process whereby the PCRS framework can be adapted to ensure that specific competencies can be developed to address the needs of specific populations.⁴³ Numerous articles in the medical literature document that many individuals with diverse backgrounds (including race, ethnicity, religion) and identities (e.g., sexual orientation) or populations affected by various medical conditions (e.g., mental health disorders, HIV/AIDS) suffer from health disparities and inequities in health care.

Improving the training required to provide high quality, culturally informed care to such marginalized or underrep-

resented populations need not be done outside the scope of the already demanding core curriculum. Eckstrand et al.’s model process to incorporate content- and context-specific qualifiers to address gaps in training regarding underrepresented populations comprises five major steps: (1) selecting a competency framework (i.e., the PRCS), (2) identifying gaps in performance, (3) selecting competencies to qualify, (4) writing the qualifiers, and (5) iteratively editing the qualifiers (Table 3).⁴³

Several models for convening multidisciplinary groups of experts to develop competencies and content- and context-specific qualifiers have been published in the medical literature. For example, the American Association of Medical Colleges convened the Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development to develop a set of competencies for undergraduate medical education to improve health care for individuals who are LGBT, gender nonforming, or born with differences in sexual development.⁴³

Bayer et al. reported on the competency development process that experts across sexuality disciplines used to develop comprehensive, standardized sexual health competencies for undergraduate medical education to address the wide range of sexual concerns that patients experience.⁴⁴ This particular initiative built off the model process described by Eckstrand et al. and resulted in the articulation of 20 sexual health competencies and 34 qualifiers aligned with the eight overall domains of competence as delineated in the PRCS. Bayer et al. slightly modified the Eckstrand process to include psychological aspects of sexual health, as an integrated biopsychosocial approach is so critical to addressing sexual health issues.

Developing FGC Competencies

Physician competencies to address the major gap in care that exists for girls and women who have undergone FGC can be developed by both mapping to the established PRCS and articulating content- and context-specific qualifiers to address the myriad health care needs of this highly marginalized population. We propose, as next steps, the establishment of a multidisciplinary team of FGC experts and experts in the competency development process to undertake this mission. FGC physician competencies need to address a range of issues, including but not limited to issues involving knowledge for practice (e.g., definition and types of FGC, best practices

TABLE 3. STEPS FOR ADAPTING THE PHYSICIAN COMPETENCY REFERENCE SET TO DEVELOP COMPETENCIES TO ADDRESS UNDERSERVED POPULATIONS AND OVERLOOKED HEALTH CONDITIONS

<i>Step</i>	<i>Purpose</i>
1. Select PCRS as competency-based medical education framework.	Select a broadly utilized framework in medical education.
2. Identify gaps in performance.	Establish the evidence-based need for improved physician knowledge, skills, and attitudes to address the health of a population.
3. Determine which PCRS competencies require content- or context-specific qualifiers to address gaps.	Support and streamline integration into existing competency-based curricula.
4. Create qualifiers of competence that are assessable.	Facilitate evaluation of competence across cognitive, affective, and skill/behavior domain.
5. Develop an iterative process for editing qualifiers.	Achieve consensus on competencies that require qualifiers and finalize qualifier language.

Adapted from: Eckstrand et al.⁴²
PCRS, Physician Competency Reference Set.

TABLE 4. AREAS FOR CONSIDERATION IN DEVELOPING FEMALE GENITAL CUTTING COMPETENCIES

1. Definition of FGC, awareness of cultural practices, and their prevalence.
2. Knowledge about anatomy, physiology, and sexuality of women with FGC.
3. Correct identification and documentation of the types of FGC in the adult and pediatric populations.
4. Screening tools for identification of women/girls who have undergone FGC and for identification of girls who are at risk.
5. Clinical management of FGC complications, including obstetrical issues; urological and gynecological issues; and psychological, psychiatric, and behavioral sequelae.
6. Understanding of the complex and varied sexual health issues/concerns among FGC women and cultural skills in discussing sexuality.
7. Development of professional attitudes that are nonjudgmental and do not contribute to the stigmatization of women who have undergone FGC.
8. Provision of holistic, multidisciplinary, nondiscriminatory, culturally sensitive, and trauma-informed care, with a nuanced approach to expectations about FGC women's sense of femininity and their sexual functioning.
9. Counseling tools for requests for reinfibulation postdelivery.
10. Knowledge about and counseling skills around surgical repair of external genitalia, including clitoral reconstruction.
11. Understanding of legal prohibitions established by federal and state laws, and mandatory reporting requirements.
12. Understanding of the range of ethical dilemmas raised by the practice and guidelines for resolving them.
13. Knowledge of resources and services for ongoing social support and group therapy/support.
14. Best practices for the prevention of FGC regarding both the identification of at-risk girls and broader engagement with practicing communities.
15. Best communication practices with families around the legal prohibition of FGC and preemptive counseling of affected women to prevent FGC being undertaken in the girls at risk in the family.
16. Best communication practices and education strategies for engaging with immigrant communities.
17. Engaging in advocacy and partnering with organizations engaged in community-based activities.

FGC, female genital cutting.

for clinical management, relevant psychosocial issues, laws, and reporting requirements); patient care (diagnostic and treatment skills, provision of trauma-informed care); dealing with ethical dilemmas (beneficence vs. patient autonomy and dual loyalty scenarios); communication skills (cultural sensitivity and nondiscriminatory practice); interprofessional collaboration (reporting processes, knowledge of community resources, working with community activists); and best practices regarding prevention (within individual families and in FGC-practicing communities at large).

Table 4 presents a number of topic areas that should be taken into account in the development of an FGC competency list. Once developed, FGC competencies can be integrated across various modules and courses in the 4-year undergraduate curriculum, for example in social determinants of health modules, anatomy and organ system courses, history taking and physical exam sessions, physician communication modules, sexual health and ethics courses, as well as in a number of clinical rotations, especially obstetrics/gynecology, pediatrics, family medicine, internal medicine, emergency medicine, urology, and psychiatry. The competencies can be taught utilizing a variety of education methods, including didactic lectures, problem-based learning, case presentations, small group discussions, objective structured clinical exams, grand rounds presentations and self-directed learning. To complete the process, performance standards for each competency needs to be developed as well as corresponding evaluation tools to assess that competencies and patient care outcomes are being met.

Beyond undergraduate medical education, further steps include the creation of a variety of FGC education materials for residents, interns, and fellows in a variety of specialties during their graduate medical education, and for postgraduate health care professionals who are in practice. Specialists, such as pediatricians, child abuse experts, obstetricians/gynecologists, midwives, family medicine physicians, internists, and emergency medicine physicians, should prioritize education and

training. One method of expediting the integration of FGC education and training into undergraduate and graduate curricula is to advocate for inclusion of FGC questions on licensing exams, including the USMLE STEP examinations and specialty boards, and board recertification examinations.

Clinicians also need to partner with key stakeholders, such as police and child protective service workers to advocate for formal, culturally sensitive training of these groups, and community members and affected individuals to develop culturally sensitive patient education materials. Finally, the development of standardized competencies through a rigorous, formal process and the subsequent creation of educational programs to achieve them would help inform state legislators who are drafting new bills or appending current laws on best educational practices. Standardized competencies would also assist in the promulgation of comprehensive educational initiatives as various states attempt to engage in education and outreach to health care professionals and other key stakeholders in the community.

Conclusion

U.S. health care providers will invariably see more women and girls who have already undergone FGC, given the influx of immigrants from FGC-practicing countries into communities across America. There is an urgent need to improve education and training on FGC; the first step in doing so is to convene a working group to develop comprehensive competencies that align with the standardized list of physician competencies articulated in the PRCS. Other professional groups will hopefully engage in similar competency development initiatives, providing the opportunity to collaborate across disciplines. Successful models exist for engaging in such competency development. By integrating comprehensive, evidence-based education and training on FGC at all levels of medical education and across a number of disciplines, HCPs will be able to provide team-based, high-

quality, culturally sensitive care to the hundreds of thousands of affected women and girls in the United States, and also work to prevent the practice from being carried out on girls who are at risk here but have not yet been cut.

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Address correspondence to:

*Holly G. Atkinson, MD, FACP, FAMWA
CUNY School of Medicine
160 Convent Avenue
Harris Hall, Suite 111
New York, NY 10031*

E-mail: hatkinson@med.cuny.edu