Consider the Personhood of Women Who Experienced Genital Cutting

To the Editor: In the article published in the June 2013 issue of *Mayo Clinic Proceedings*, Hearst and Molnar[1] reported comprehensive data regarding female genital cutting in African and Middle Eastern women. Although their report was educative and meaningful, they overlooked how the human aspect of these women is affected by the cultural imperatives that dominate their lives. Female immigrants are much more than the condition of their genitals. They have varying needs and levels of acculturation with differing views and experiences.

Focus group research reveals that these women are frustrated and often feel disrespected when physicians' questions quickly switch from the presenting problem to female genital cutting. One 65-year-old woman asked, "Why do you ask me so much about this?,…My back hurts, I need a job and my family to be together again. These are my problems."[2] Raising Kleinman's questions[3] may give these women the sense that a clinician respects them and their viewpoints: (1) What do you call the problem? (2) What do you think has caused the problem? (3) Why do you think it started when it did?

When caring for African women, we remind clinicians that African cultures are typically based on an oral tradition. If clinicians build rapport and trust by listening to patients' stories, they may hear of deep love toward children and extended family, respect for elders, and actions weighed on the basis of impact on community. They may hear about trauma experienced in leaving a war-torn country or difficulties raising children in a new culture without family and community support as experienced back home.

We recommend a stance of respectful curiosity to sensitively partner with these immigrant families. Carl Rogers said, "If I can be genuinely understanding, listen not only to the words but to the meaning, that is helpful.…If I really care about this person in an unconditional way, that's helpful. If I can really be myself in the relationship, not a professional expert, not a psychoanalyst, not a psychotherapist, just me in that relationship, that is helpful."[4] Instead of condemning traditional practices and leading women to be defensive, a Somali woman requested, "Educate the family [considering circumcising their daughter]...You can explain the consequences, what is going to happen. She may have psychological trauma, bleeding, she may get infection, it may affect fertility…They will understand. The Somalian people understand when you explain to them and make them understand."[5]

A. Renée Bergstrom, EdD (ret)
Filsan Nur, BS
Mayo Clinic
Rochester, MN

Denise Lynne Davis, MD
University of California, San Francisco
San Francisco VA Medical Center
San Francisco, CA

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In reply—Consider the Personhood of Women Who Experienced Genital Cutting

We thank Bergstrom and colleagues for their letter in response to our article on female genital cutting (FCG). We are delighted by their thoughtful reading of our article, and we agree with the important points that they make regarding cross-cultural medicine in general and caring for women who have undergone FGC specifically.

They rightly point out that our review article focused mostly on medical management. As we mentioned in the article, the practice and cultural meaning of FGC varies so much across different ethnicities in Africa and the Middle East that we were not able to fully address the many specific cultural aspects of FGC. We did attempt to emphasize the importance of understanding each woman's experience and her cultural context when meeting and caring for women who have undergone FGC. The goal of Table 2 in our article was to help physicians who may be less familiar with cross-cultural medicine to better understand how women would like the topic of FGC to be approached, if at all. We also stated:

> In practice, many physicians simply avoid discussion of FGC, which can be frustrating and confusing to the woman with FGC, especially as she anticipates delivery and possible episiotomy. On the other end of the spectrum, women with FGC have expressed concern that their FGC turns them into "specimens" and the presence of the FGC becomes more fascinating to their physician than her presenting health concern or the woman as a whole. Women with FGC have expressed that they want their physicians in America to know that they are circumcised but do not necessarily want to discuss it unless there is a current or anticipated problem.[2]

These statements and the information provided in Table 2 of our article were gathered from focus groups and the

excellent article by Khaja et al,[1] which Bergstrom et al also cited.

Female immigrants from countries where FGC is practiced certainly are "more than the condition of their genitals." We agree that eliciting a narrative and attempting to truly understand these women's experiences is an integral part of providing compassionate and culturally competent care. We chose to focus on clinical aspects of this topic because, as health care professionals, one of our first responsibilities is to also understand the potential health consequences of any patient condition. Women in focus groups have also reported frustration with physicians' lack of knowledge. To communicate effectively with any patient, the clinician must be properly informed. We encourage interested health care professionals to read the article by Khaja et al[1] and for researchers to continue to explore both the medical and communication issues in future research. Certainly excellent patient care cannot take place with just one or the other.

Adelaide Hearst, MD
Alexandra Molnar, MD
University of Washington
Seattle

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Trends in Pneumonia Hospitalizations in Hennepin County, Minnesota, 1999-2010

To the Editor: The introduction of the 7-valent pneumococcal conjugate vaccine (PCV7) in 2000 led to a decline in pneumococcal disease in children and adults.[1,2] Although rates of pneumonia hospitalizations decreased in children after PCV7 introduction,[3] these gains were offset by an increase in pneumonias complicated by necrosis and empyema, including disease caused by serotypes not contained within the vaccine.[4] We sought to describe the epidemiology of pneumonia hospitalizations in Minnesota over 12 years, before and after the introduction of conjugate vaccines.

Patients and Methods. We conducted a retrospective study of pneumonia hospitalizations from 1999 through 2010 based on hospital discharge codes in the Fairview Health Services network in Minnesota, a state with 96.7% uptake of PCV7 among children. Fairview Health Services in Minnesota encompasses 6 hospitals in the greater Twin Cities (Minneapolis and Saint Paul) of Hennepin County, serving more than 1 million patients with 175,000 emergency department visits and over 73,000 inpatient admissions per year. A case of pneumonia hospitalization was defined as a record with any of the following *International Classification of Diseases, Ninth Revision* (*ICD-9*) codes assigned as the primary diagnosis: 073.0, 481, 482.2, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.89, 482.9, 483.0, 483.1, and 486. A primary diagnosis of empyema was identified using *ICD-9* codes 510, 510.0, and 510.9.

Cases were grouped by age (<2 years, 2-4 years, 5-18 years, 19-49 years, 50-64 years, and 65 years and older) and *ICD-9* code. The study dates span the pre-PCV7 (1999-2000), early post-PCV7 (2001-2004), and late post-PCV7 (2005-2010) eras. Standard linear regression was used to calculate trends for 1999-2004 and 2005-2010, and a formal test of the interaction was completed to determine if the trends differed between time periods.

Results. A total of 14,807 hospitalizations were documented with a pneumonia-related *ICD-9* diagnosis between 1999 and 2010. From 1999 through 2004, the pre- to early post-PCV7 periods, a significant decrease in pneumonia hospitalizations was seen for children less than 2 years of age (P=.028) and those in the 2- to 4-year age group (P=.032), as well as among adults in the 50- to 64-year age group (P=.039) and among those over 65 years (P=.008). A significant decrease in pneumonia hospitalizations was also observed from 2005 through 2010 for children less than 2 years of age (P=.013) and children between the ages of 2 and 4 (P=.033), but no significant trend was observed for older individuals. The most common pathogen-related pneumonia diagnosis was pneumococcal pneumonia, followed by staphylococcal pneumonia (Figure; data was based on *ICD-9* codes, and staphylococcal pneumonia represents all relevant *ICD-9* codes [482.40, 482.49, 482.41]. As stated in the limitations, the largest diagnostic entity was the general diagnosis of 'pneumonia' but we did not abstract the data to ascertain the pathogens involved).

Discussion. Our findings indicate that pneumonia hospitalizations decreased in both young children and older adults in the early post-PCV7 period, although the decrease was only sustained in the younger children. This finding has been noted in other studies.[2] In addition, our results are similar to those in studies that have documented the effectiveness of PCV7 in reducing the incidence of pneumonia in young children,[4] as well as decreasing disease in adults as a result of the "herd effect."[1] In contrast, the availability of the 23-valent pneumococcal polysaccharide vaccine, which has been effective in reducing pneumococcal bacteremia, has not reduced the risk of community-acquired pneumonia.[5]

An increase in methicillin-resistant *Staphylococcus aureus* pneumonia in the late post-PCV7 period may be a result of nasopharyngeal eradication of vaccine-related *Streptococcus pneumoniae*