

A recent *CMAJ* lead editorial notes that failures to manage patients according to widely accepted standards of care may be more common than the medical errors that result in serious adverse events in Canadian hospitals.¹ The editorial goes on to suggest that “process-of-care standards could be implemented in hospital and ambulatory practice; adherence could be monitored and the results disclosed.”¹

In BC we have established many standards of care through our clinical practice guidelines and we monitor adherence to many of them through administrative data. We can easily confirm your suspicion concerning the prevalence of failures to manage patients according to accepted standards of care.²

I am dismayed that you feel that public disclosure of the results of such monitoring will push physicians to improve their scores. This approach is rooted in the culture of blame that bedevils our health system and that so often leads to selective reporting, gaming, concealment and lack of cooperation with otherwise promising quality improvement initiatives. Measurement should be for learning, not for judgment. In BC we offer software that provides doctors with their performance measures in the privacy of their own office. I believe this creates a safe environment where doctors can learn to improve the care they provide and that making the results public would detract from this process.

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Female genital mutilation

Shame on *CMAJ* for using the term “female circumcision.”¹ More than a decade ago, the UN seminar on Traditional Practices Affecting the Health of Women and Children (Burkino Faso, 1991) recommended that the term “female genital mutilation” be used instead.²

The word “circumcision” downplays the appalling nature and consequences of female genital mutilation. The WHO states that “excision of the clitoris and labia minor ... are the commonest types of female genital mutilation. They constitute up to 80% of all female genital mutilation practised.”² It is obvious that female genital mutilation and male circumcision are not analogous. Use of the term “female circumcision” obscures the issue and does a disservice to your readers and to all girls and women.

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[The author responds:]

Phillipa Rispin is correct that the United Nations has recommended the term “female genital mutilation (FGM)” rather than “female circumcision”; however, as the editors point out, some people would feel insulted by the term “mutilation.” In the case we described,¹ the parents clearly used the term “circumcision” rather than “mutilation” in describing their daughter’s medical history. I agree that “female circumcision” is not analogous to male circumcision, and Box 1 in our article clearly describes what can be involved in FGM. As health care professionals, it is important to be culturally sensitive, while at the same time being aware of

health practices that can potentially harm our patients and educate families accordingly.

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[The senior deputy editor responds:]

We thank Phillipa Rispin for drawing this to our attention and agree that the term “female circumcision” is an inappropriate euphemism. However, some clinical practice guidelines have pointed out that not all women who have undergone genital modification in its various forms consider themselves mutilated and may be insulted by the term “female genital mutilation.”¹ Terms such as “traditional female surgery,” “ritual female surgery” and “female genital cutting” have been proposed by some groups as nonjudgmental alternatives. However, in view of the serious harms associated with these practices and the disempowerment of the majority of girls and young women who are affected, we defer to the WHO’s recommendation and have adopted “female genital mutilation (FGM)” as the preferred term in our style guide. Canadian physicians should bear in mind, however, that while FGM is not legal in this country, the terms they use in discussing this practice and its consequences with patients need to be culturally sensitive.

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