

WEBVTT

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00:00:00.020 --> 00:00:01.470

Dean's Lecture Series: To another installment

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00:00:02.130 --> 00:00:26.119

Dean's Lecture Series: of the Dean's lecture series. So I'm Anthony Wallace, and I am a learning and development manager in the office of diversity, equity, and inclusion here at the University of Minnesota Medical School. Just as a heads up. This session will be recorded and shared out within 2 days to everybody who registered for this event. Otherwise you can access the recording on under the education and training tab of the Odei website.

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00:00:26.330 --> 00:00:44.269

Dean's Lecture Series: So live transcription has been enabled. But we do want to note that this live transcript isn't perfect, as it is an auto transcript through zoom we also invite you to take care of yourself as necessary during today's session as we will not be taking a break between the lecture and the QA section of the event.

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00:00:44.598 --> 00:01:08.019

Dean's Lecture Series: Any feedback, or if you have any feedback or issues with accessibility, we really do welcome you to email us and let us know. You can contact us at DIs dash odei@umn.edu. That email is also provided in the chat. We ask that all participants, as far as submitting questions. Use the QA. Function instead of the chat. In order to ask questions of our presenter, Dr. Connor. Today

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00:01:08.020 --> 00:01:14.309

Dean's Lecture Series: we will do our best to respond. But please understand that we're working with a set window of time. As we're wrapping up around 10 o'clock.

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00:01:14.390 --> 00:01:22.060

Dean's Lecture Series: Should we not get to your question, we will work with the presenter to get any unanswered questions posted on the deeds. Lecture series. Web page.

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00:01:22.240 --> 00:01:30.859

Dean's Lecture Series: paste it in the chat you will find links to the DIs website, the slides to our presenters lecture today and the Dean's Lecture Series email address

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00:01:31.010 --> 00:01:37.120

Dean's Lecture Series: with all of that housekeeping done, I will turn it over to Dr. Nunez to introduce today's guest lecturer.

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00:01:37.580 --> 00:01:38.640

Ana Núñez MD: Thank you, Anthony.

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00:01:38.730 --> 00:02:08.589

Ana Núñez MD: Good morning, everybody. Welcome to our Dean's lecture series in terms of August. We were just talking as we set up about the joys of the dog days of August. Dog days actually has to do with constellations, not dogs. But we were talking about enjoying the amazing weather that we have out there. So I'm hoping all of you have been doing that throughout the summer. We're we're back, if you will, in terms of our medical students, join us next week. So excited to kind of get back

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00:02:08.590 --> 00:02:22.110

Ana Núñez MD: and the swing of things, and so to sort of kick us off in terms of that. We have a presentation today called patient-centered communication in the context of female genital cutting

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00:02:22.110 --> 00:02:48.799

Ana Núñez MD: implications from the our body. Our Health research study, and our presenter is Jennifer Jo. Connor, Phd. A licensed marriage and family therapist. She's associate professor here at the University of Minnesota, at the Eli Coleman Institute for Sexual and Gender Health, which is part of the Department of Family Medicine and Community Health. She's the director of Clinical Services at M. Health, Fairview sexual and gender health clinic.

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00:02:48.800 --> 00:03:11.510

Ana Núñez MD: and her research interest is in sexual pain due to Volvodynia and female genital cutting. So really interesting sort of conversation. Things we would probably talk, not enough about in terms of some of these issues, and important to sort of see the entire spectrum of how that men manifest with all of our different communities. So welcome, Dr. Connor, I'll turn it over to you.

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00:03:26.100 --> 00:03:40.910

Jennifer Connor: Thank you, Dr. Nunez. Yes. So today I'm going to talk about patient centered communication. In the context of female genital cutting, as was just said. And I'm going to bring in results from a research study that I've been involved in for the last several years.

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00:03:41.398 --> 00:03:50.390

Jennifer Connor: And but before we get into the conversation. It's important that I acknowledge my own background and how that might show up.

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00:03:56.380 --> 00:04:03.561

Jennifer Connor: there we go. Okay. So I am a licensed marriage and family therapist have been for 30 years

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00:04:04.000 --> 00:04:14.589

Jennifer Connor: and also faculty members. So I do both clinic research. I used to do quite a bit of education less so now, and my areas

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00:04:14.670 --> 00:04:20.659

Jennifer Connor: is not just not just related to the topic at hand, but also

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00:04:20.709 --> 00:04:23.889

Jennifer Connor: more globally. Sexual pain and sexuality.

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00:04:26.300 --> 00:04:38.640

Jennifer Connor: I started with a research career in Volvodynia and kind of through a series of events that has morphed into looking more at email, genital cutting.

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00:04:39.221 --> 00:04:56.080

Jennifer Connor: My own social position is I'm a cisgender female. I was raised in Central Minnesota. I did Catholic schooling and that shows up in all kinds of ways, and not necessarily expected or wanted. When I study sexuality

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00:04:56.462 --> 00:05:11.769

Jennifer Connor: and unlike the the women I'm going to talk about today. My ancestors have been in the Us. For quite some time, and that's another important piece is that I don't necessarily have a real strong understanding other than

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00:05:11.830 --> 00:05:17.149

Jennifer Connor: through talking to participants and research staff of what it's like to move to another country.

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00:05:19.430 --> 00:05:21.050

Jennifer Connor: But I'm trying to understand

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00:05:23.490 --> 00:05:24.190

Jennifer Connor: so

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00:05:25.600 --> 00:05:27.300

Jennifer Connor: as as I've

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00:05:27.500 --> 00:05:34.329

Jennifer Connor: delve more and more into this topic. I have had many informal conversations

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00:05:34.380 --> 00:05:39.270

Jennifer Connor: where someone says, I don't know how to talk to my patients about female genital cutting.

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00:05:40.850 --> 00:05:59.230

Jennifer Connor: This led us to include a question in the survey. That we did that says, do you think your current primary care, doctor pays enough attention to your circumcision. This was just purely curiosity wasn't directly create linked to our aims. But the findings were interesting.

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00:05:59.649 --> 00:06:19.790

Jennifer Connor: Where 46% of women said that their their doctor did not pay enough attention to their circumcision, and only 6% said that they paid too much attention. So today's objective is really to just unpack what that might mean? And try to understand

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00:06:19.820 --> 00:06:23.419

Jennifer Connor: the answer to how do people talk to patients

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00:06:25.360 --> 00:06:31.469

Jennifer Connor: before I get into description of the study. I want to talk about terminology.

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00:06:31.680 --> 00:06:32.730

Jennifer Connor: and

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00:06:32.930 --> 00:06:35.710

Jennifer Connor: so I I

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00:06:35.720 --> 00:06:39.009

Jennifer Connor: often use the term female genital cutting.

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00:06:40.430 --> 00:06:54.089

Jennifer Connor: However, in certain contexts I might use the term female genital mutilation. That is a term used by advocates. It's a term used in the lcd, and it's a term used by the World Health Organization.

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00:06:54.560 --> 00:06:56.770

Jennifer Connor: However, many folks

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00:06:57.060 --> 00:07:01.520

Jennifer Connor: who have migrated to a country that doesn't practice Fgc

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00:07:01.530 --> 00:07:06.629

Jennifer Connor: find that term to be offensive and stigmatizing, and so I've

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00:07:06.640 --> 00:07:09.259

Jennifer Connor: really only used it when I've been

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00:07:09.320 --> 00:07:29.719

Jennifer Connor: in Africa talking to people who are using that term in their own communities. But the community in Minnesota, especially the Somali community is like what I'm most familiar with tends to use the the language of female circumcision, and so, depending on my audience, I might go back and forth between Fgc. And female circumcision.

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00:07:31.271 --> 00:07:39.220

Jennifer Connor: In terms of patience I would probably use the term female circumcision, and Fgc. Is what I use in the in the academic literature.

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00:07:41.430 --> 00:07:48.880

Jennifer Connor: also important to know, there are different types of Fgc, I'm not going to go into them in great detail.

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00:07:49.880 --> 00:08:03.739

Jennifer Connor: But again, academics are going to use kind of different terms than community, often, so speaking, only to the Somali community. At this point, the Somali community tends to use 2 terms, Suna and Veronic.

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00:08:04.211 --> 00:08:15.160

Jennifer Connor: As a physician you might use type one type 2, type, 3, type, 4, or you might use for type 3. You might use the term infibrillation.

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00:08:16.750 --> 00:08:45.850

Jennifer Connor: What's important to know is what is deinfibulation. I'm going to refer to that throughout the talk. But also, I've heard. Physicians use this incorrectly. So deinfibrillation refers to opening the narrowed vaginal orifice. It's not the same as clinical reconstruction surgery, and it's not the same as closing the orifice. So it's opening. And it's necessary for vaginal childbirth. And it also alleviates pain, urinary problems and menstrual problems.

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00:08:47.420 --> 00:09:14.789

Jennifer Connor: I'm not going to spend a lot of time on complications other than to say, there's no known benefits to fgc, there are some acute concerns. Typically because people don't practice fgc, in this country. We won't see that as much. The acute concerns we may see long term concerns. So the long term complications are obstetric issues, genital pain, urinary menstrual issues, sexual dysfunction.

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00:09:15.250 --> 00:09:25.191

Jennifer Connor: some potential psychological. And there is some studies that that are pointing to potential problems with neonatal health. However, if you look at the

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00:09:26.590 --> 00:09:45.130

Jennifer Connor: the meta analyses, you'll find that there's a great heterogeneity and findings, and this really points to the complexity and diversity of what is often spoken to as just 4 types. But really, we're talking about many, many different ethnicities across 30 different countries.

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00:09:45.160 --> 00:09:48.740

Jennifer Connor: And we're also talking about anything from a prick

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00:09:48.830 --> 00:09:50.090

Jennifer Connor: to

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00:09:50.716 --> 00:10:06.189

Jennifer Connor: removing large parts of the genital and sewing things shut. And so it's so. It makes a lot of sense that there would be heterogeneity and findings. When you think about there's heterogeneity and culture, heterogeneity and anatomical modification.

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00:10:07.358 --> 00:10:09.510

Jennifer Connor: The other. The other

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00:10:09.740 --> 00:10:15.739

Jennifer Connor: complication that may come up is case, there are sometimes Keloids or Sis.

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00:10:20.250 --> 00:10:31.039

Jennifer Connor: So I'm gonna describe our study very briefly. Our study took place from 2,018 to 2,024. It just ended officially, June 30th

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00:10:31.543 --> 00:10:53.050

Jennifer Connor: and it's a Cbr. Cbpr. Study with both qualitative and quantitative aims, exploring sexual pain in Somali women living in the Us. Or in Minnesota. Who experienced Fgc, so our group, because Fgc. Doesn't happen in the United States. All of our group was born outside of the Us.

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00:10:54.370 --> 00:10:59.190

Jennifer Connor: So we did 75 qualitative interviews and 300 surveys.

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00:10:59.250 --> 00:11:14.999

Jennifer Connor: and important to know within the Somali community, not necessarily in other like librarian communities or other communities. You might see in Minnesota, the Somali community has a large percent of type 3 or infibrillation.

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00:11:15.500 --> 00:11:29.440

Jennifer Connor: We also did a side project that was kind of instigated by a research assistant called Zoom. Object here, and called Zoom is a nursing student who wanted to look at how people charted

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00:11:29.460 --> 00:11:32.729

Jennifer Connor: Fgc. And so we did a

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00:11:33.000 --> 00:11:52.569

Jennifer Connor: random chart review of 100 accounters and looked at notes from people who use the lcd Fgm codes. And so that group is slightly different in that. It wasn't limited to Somali ethnicity. So. But the majority of the participant or the patients were from East Africa.

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00:11:56.370 --> 00:11:57.420

Jennifer Connor: So

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00:11:58.150 --> 00:12:04.759

Jennifer Connor: this is a large team. Not in addition to hundreds of participants and patients

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00:12:05.030 --> 00:12:10.679

Jennifer Connor: we had, I'm gonna just really, briefly, and later I'll show names.

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00:12:11.290 --> 00:12:13.960

Jennifer Connor: So in the left hand corner

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00:12:14.140 --> 00:12:20.630

Jennifer Connor: by the M is our beginning core team, who did most of the data collection, the qualitative analyses

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00:12:21.143 --> 00:12:25.079

Jennifer Connor: in the bottom left. You see, our community Advisory Board

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00:12:25.320 --> 00:12:35.220

Jennifer Connor: in the top right is investigators, data analysts, and our main interviewer minera and then the bottom right is

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00:12:35.360 --> 00:12:39.380

Jennifer Connor: people that join the team a little later. So

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00:12:39.410 --> 00:12:44.589

Jennifer Connor: they are. Also, one is, one is data analyst, and the other 2 are interviewers.

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00:12:47.690 --> 00:12:51.910

Jennifer Connor: So that's our team and our study. So I'm going to come back to

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00:12:52.690 --> 00:12:58.219

Jennifer Connor: this question. Do you think your current primary care doctor pays enough attention.

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00:12:58.460 --> 00:13:05.860

Jennifer Connor: And so so since that wasn't the main reason we did this study, we didn't really. We didn't really build in

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00:13:05.960 --> 00:13:14.789

Jennifer Connor: enough to answer the question, but it's possible. And I'll talk about why that is related to knowledge of physicians.

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00:13:14.870 --> 00:13:28.940

Jennifer Connor: attitudes, and assumptions that healthcare providers have communication skills and then logistics. I'm not going to talk about other than to acknowledge that all most health care providers are not given enough time with their patients.

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00:13:32.420 --> 00:13:50.920

Jennifer Connor: So starting with what I think is one of the 1st reasons that maybe people are not having the conversations. Is that there's a misconception that women with Fgc. Are not interested in sexual health, and I've heard this in many different settings. You may have as well. I've heard it in presentations.

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00:13:51.060 --> 00:13:52.340

Jennifer Connor: writing

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00:13:52.480 --> 00:13:55.015

Jennifer Connor: cocktail parties, whatever.

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00:13:55.880 --> 00:13:59.029

Jennifer Connor: There! It's pretty general. Believe that

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00:13:59.420 --> 00:14:06.519

Jennifer Connor: this group of women are from patriarchal societies, and they were mutilated, and therefore they're not interested?

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00:14:06.932 --> 00:14:19.259

Jennifer Connor: Well, I don't think so. So what does the research say? In the chart review study, we found that 31% of the encounters address sexual health. So this means that women who are coming

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00:14:19.690 --> 00:14:22.710

Jennifer Connor: to their physicians to talk about

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00:14:23.020 --> 00:14:24.330

Jennifer Connor: Fcc.

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00:14:24.420 --> 00:14:29.429

Jennifer Connor: Are also a 3rd of them, almost a 3, rd are also talking about sexual health.

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00:14:29.620 --> 00:14:33.389

Jennifer Connor: I thought that the number for obstetrics would be higher.

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00:14:34.043 --> 00:14:44.199

Jennifer Connor: But that was actually only 9%. So more more women were seeking services related to sexuality than they were related to having babies.

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00:14:45.530 --> 00:15:04.930

Jennifer Connor: Another thing that we found is that in the qualitative study we recruited months faster than we expected. We had really wonderful interviewers. People wanted to talk to them. They were bilingual interviewers, and the majority of the interviews were done in Somali

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00:15:05.730 --> 00:15:12.569

Jennifer Connor: And they kept referring their friends and neighbors. So, for example, Minera, who did many of the interviews,

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00:15:13.040 --> 00:15:21.720

Jennifer Connor: would sometimes be at an apartment building till 10 o'clock at night, because people kept saying, now you should talk to this neighbor. So people really wanted to talk.

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00:15:22.120 --> 00:15:28.149

Jennifer Connor: The quantitative study was a little different, because Covid happened right before we were going to start data collection.

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00:15:28.230 --> 00:15:33.149

Jennifer Connor: If we remove some barriers, we still recruited slightly faster than expected.

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00:15:34.270 --> 00:15:46.570

Jennifer Connor: Also our study and others have found that though Ftc. Is associated statistically with a higher odds of sexual dysfunction, it's not a universal experience. So meaning that

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00:15:47.670 --> 00:15:51.819

Jennifer Connor: you know, we're only talking in means and statistical significance

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00:15:52.180 --> 00:16:07.564

Jennifer Connor: when we read studies about. Yes, it is associated with sexual dysfunction. But there's a large group of women who don't have sexual dysfunction. And even women that do have sexual dysfunction are seeking healthcare. So

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00:16:08.350 --> 00:16:11.389

Jennifer Connor: that, too, that idea that

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00:16:11.590 --> 00:16:21.379

Jennifer Connor: once this happens, you are interested in sexuality is is not universally true. It's, of course, true for some women, because that's true for some women in all cultures

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00:16:21.740 --> 00:16:23.409

Jennifer Connor: and other genders as well.

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00:16:25.170 --> 00:16:27.934

Jennifer Connor: so. And by the way, I'm gonna use

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00:16:28.550 --> 00:16:29.740

Jennifer Connor: women,

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00:16:31.590 --> 00:16:36.050

Jennifer Connor: mainly because we don't. We? All all the women in the sample were cisgender

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00:16:38.415 --> 00:16:39.420

Jennifer Connor: alright.

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00:16:39.430 --> 00:16:55.880

Jennifer Connor: The other thing that we found in the qualitative as well as others is that sometimes women would go to a physician and say, I want to have deinfibrillation, or have some kind of intervention, and the physician would say, That's not culturally appropriate for you.

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00:16:56.060 --> 00:17:02.490

Jennifer Connor: And they would override the patient's request. So that also tells me that there are a lot of misconceptions

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00:17:02.510 --> 00:17:04.349

Jennifer Connor: and some

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00:17:04.880 --> 00:17:12.000

Jennifer Connor: some beliefs that you know. I can tell you what your culture wants. And therefore I'm gonna

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00:17:12.079 --> 00:17:15.040

Jennifer Connor: I'm I'm going to override what you think you want.

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00:17:15.819 --> 00:17:25.660

Jennifer Connor: And there's been studies that said that often patients and physicians are not on the same page. These studies were actually done in in Europe. And that

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00:17:26.319 --> 00:17:34.549

Jennifer Connor: often again there was an assumption that the patient wouldn't want any intervention rather than asking the question, would you like an intervention?

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00:17:38.540 --> 00:17:39.580

Jennifer Connor: Oh, sorry.

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00:17:40.630 --> 00:17:41.430

Jennifer Connor: Okay.

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00:17:41.620 --> 00:17:43.490

Jennifer Connor: The other thing from our study

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00:17:43.870 --> 00:17:51.810

Jennifer Connor: is, we included a decisional conflict scale and that was related to did.

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00:17:52.810 --> 00:18:00.630

Jennifer Connor: Did you have any conflict? Internal conflict about getting deinfibrillated? And this was only asked of women who did get deinfibrillated

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00:18:01.307 --> 00:18:03.870

Jennifer Connor: and their sub scales of informed.

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00:18:04.260 --> 00:18:06.830

Jennifer Connor: so meaning. Did you have enough information?

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00:18:06.850 --> 00:18:12.660

Jennifer Connor: Were you uncertain? Were you clear of your values? And did you get the support from healthcare providers?

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00:18:13.120 --> 00:18:20.819

Jennifer Connor: The Hi by the way, this is a medical student who's leading this analysis. So Shreya Shanda, and

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00:18:20.900 --> 00:18:25.700

Jennifer Connor: the highest conflict scale was informed that people didn't know their options.

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00:18:25.890 --> 00:18:29.140

Jennifer Connor: and the lowest conflict scale was

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00:18:29.190 --> 00:18:37.850

Jennifer Connor: 2. They're very similar values, clarity and uncertainty. So I'm going to paraphrase Shreya's words here that

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00:18:38.250 --> 00:18:44.639

Jennifer Connor: women know what they want, and they and they have an idea of who they are and what their values are.

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00:18:45.260 --> 00:18:49.201

Jennifer Connor: But they might not always get the information that they need

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00:18:50.310 --> 00:18:53.070

Jennifer Connor: And I think that, too, is an important part of

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00:18:54.220 --> 00:18:57.179

Jennifer Connor: how. That idea of like, why

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00:18:57.280 --> 00:19:03.350

Jennifer Connor: are you? Are you getting enough attention? Well, maybe not, because maybe there needs to be more information provided

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00:19:07.810 --> 00:19:13.489

Jennifer Connor: in the Chart Review study, which was very interesting. We found that

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00:19:14.380 --> 00:19:25.592

Jennifer Connor: across the 11 counters, not 1,100 encounters. There were 11 different terms used for Fgc. The most common female circumcision

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00:19:26.310 --> 00:19:27.450

Jennifer Connor: and

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00:19:27.890 --> 00:19:34.159

Jennifer Connor: but there was also clearly wrong terms used at times because they would

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00:19:34.270 --> 00:19:38.210

Jennifer Connor: contradict themselves in the notes. So, for example.

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00:19:38.370 --> 00:19:45.259

Jennifer Connor: someone might say, an amphibulated type 2 which doesn't exist by definition. Type

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00:19:45.350 --> 00:19:56.889

Jennifer Connor: 2 is not infibrillated. So this tells us as well that physicians, maybe and and other healthcare providers may not have enough information about Fgc.

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00:19:57.170 --> 00:20:05.739

Jennifer Connor: The notes lacked specificity. I was the only therapist on the study. There were us for physicians and and medical students and nursing students.

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00:20:06.275 --> 00:20:20.240

Jennifer Connor: And they had lots to say about needing more specificity, especially in teaching hospitals where you might have different physicians or residents. When the woman goes into labor.

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00:20:22.094 --> 00:20:36.669

Jennifer Connor: The other thing that was really interesting is, there were 14 different terms used for deamphibulation, and there was in, and that was among 64 of the 100 notes talked about deinfibrillation. Most often people use the wrong term

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00:20:37.216 --> 00:20:50.139

Jennifer Connor: and they might use a term that was that was inaccurate. For example, reversal, which is not a reversal, it's an opening. But you're not reversing everything that was done.

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00:20:50.720 --> 00:20:59.690

Jennifer Connor: So important again for people to learn the right terminology to give the healthcare that's needed, and to document for the next provider

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00:21:00.070 --> 00:21:08.920

Jennifer Connor: other studies. There's lots of studies done in Europe. I'm just going to highlight. 2 American studies. Have also shown that that healthcare providers

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00:21:09.600 --> 00:21:25.149

Jennifer Connor: don't feel like they have enough information about Fgc, so the levy at all. For example, 61% worked with a patient with Fgc. But only 14% had received training, and 47% felt uncomfortable.

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00:21:25.791 --> 00:21:28.559

Jennifer Connor: In the lane et Al. Study

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00:21:28.820 --> 00:21:39.750

Jennifer Connor: much bigger study across 15 cities, and only sampled reproductive health care providers, and half did not receive formal training.

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00:21:45.810 --> 00:22:00.040

Jennifer Connor: So Christina, Mayor, Mayor, I keep saying her name wrong. Maria. Did her dissertation. She's a now. She's a nursing faculty at Georgetown. Interesting dissertation about what

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00:22:00.270 --> 00:22:10.390

Jennifer Connor: predicts like, how do we know what predict who which healthcare providers have attitudes, open attitudes, and feel confident in their competency.

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00:22:10.830 --> 00:22:17.980

Jennifer Connor: And so here's a table from her. Study that what you see is that

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00:22:18.460 --> 00:22:29.800

Jennifer Connor: there's we can predict somewhat with the variables that she had who feels confident to deliver care. So we've got people who know health count complications.

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00:22:31.350 --> 00:22:33.839

Jennifer Connor: they cared for women with Fgc.

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00:22:33.850 --> 00:22:55.309

Jennifer Connor: They've received. Sorry they had. The receiving training did not rise to significance, which, I think is an interesting finding. Female personal person of color and more than 5 years of clinical experience. However, when you look to the next part, confidence and critical communication skills, the only thing that predicted whether or not someone felt

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00:22:55.800 --> 00:23:02.100

Jennifer Connor: competent to be able to communicate effectively is if they had awareness of health complications.

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00:23:02.370 --> 00:23:06.289

Jennifer Connor: So I think we have a lot of work to do in that area.

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00:23:06.750 --> 00:23:08.240

Jennifer Connor: and we also.

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00:23:08.330 --> 00:23:14.839

Jennifer Connor: we don't actually know what will help yet. I think Christina's study is the only one that's looked at this.

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00:23:15.690 --> 00:23:18.559

Jennifer Connor: So I'm going to bring in.

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00:23:21.690 --> 00:23:25.890

Jennifer Connor: I looked around at different articles about patient-centered communication.

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00:23:26.660 --> 00:23:27.920

Jennifer Connor: Just a second.

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00:23:31.990 --> 00:23:35.309

Jennifer Connor: And I, this one is from family medicine.

156

00:23:35.950 --> 00:23:39.990

Jennifer Connor: and I pulled out some of the things that I think are most relevant.

157

00:23:41.480 --> 00:23:48.770

Jennifer Connor: So one is to elicit the patient's agenda and another is to negotiate the agenda.

158

00:23:48.980 --> 00:23:59.629

Jennifer Connor: So I just had my physical a couple of weeks ago, and and when I read this article I thought, oh, he did a good job with this, he said. I have some things that I have to ask you.

159

00:23:59.690 --> 00:24:08.430

Jennifer Connor: and then I want to know what you're here for, too. Right? So Dr. Mark Nelson, thank you. So if if

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00:24:09.180 --> 00:24:14.100

Jennifer Connor: you know, leaving room to be able to to provide time

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00:24:14.700 --> 00:24:23.009

Jennifer Connor: to elicit her agenda, now at the same time talking to women from the community, and including women who are healthcare providers, and

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00:24:23.210 --> 00:24:28.161

Jennifer Connor: who are both Somali and treat Somali populations.

163

00:24:28.970 --> 00:24:39.649

Jennifer Connor: one thing that's interesting that I've heard more recently is, but that's not going to happen the 1st time you meet the healthcare provider. It's going to take some time typically

164

00:24:40.100 --> 00:24:46.049

Jennifer Connor: to build up that trust, and then I might share some things that are a little more intimate.

165

00:24:46.880 --> 00:24:51.250

Jennifer Connor: But I think if you start with some of these skills that trust will build

166

00:24:51.808 --> 00:25:05.810

Jennifer Connor: so asking open ended questions, using your active listening skills so clarifying and summarizing what you heard in this article, I will say I thought the empathy section was not as great, and in the sense of

167

00:25:06.270 --> 00:25:17.260

Jennifer Connor: the classic definition of empathy is, I'm going to put myself in your shoes, but if I really can't put myself in your shoes, and I use some of those I can imagine your feeling kind of language

168

00:25:17.310 --> 00:25:20.290

Jennifer Connor: that might come off quite disingenuous.

169

00:25:21.214 --> 00:25:26.659

Jennifer Connor: However, you certainly can demonstrate through non verbals, empathy.

170

00:25:28.580 --> 00:25:35.789

Jennifer Connor: assess the perspective on what is creating the problem. Does the does your patient feel like

171

00:25:36.130 --> 00:25:41.439

Jennifer Connor: the problem that she's coming to you with is related to Fgc. Or does she think it's another cause

172

00:25:42.032 --> 00:25:47.669

Jennifer Connor: and then, instead of assuming that there is that f 2 c has had an impact.

173

00:25:48.050 --> 00:25:59.169

Jennifer Connor: assessing, has it had an impact? Because, as I said earlier. It may or may not have had an impact. One thing I noticed in the qualitative interviews is that

174

00:26:00.916 --> 00:26:03.190

Jennifer Connor: throughout the interview.

175

00:26:05.040 --> 00:26:08.529

Jennifer Connor: as I said, the interviewers were fantastic, and they would ask

176

00:26:08.730 --> 00:26:12.979

Jennifer Connor: more and more open ended questions, and by the end

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00:26:13.480 --> 00:26:23.530

Jennifer Connor: usually more information was being given. But I think one of the ways they got there was by asking, sometimes this happens for women, did it happen for you?

178

00:26:24.266 --> 00:26:25.660

Jennifer Connor: And so

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00:26:25.810 --> 00:26:29.430

Jennifer Connor: again, not saying, How did it impact you, but

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00:26:30.230 --> 00:26:34.760

Jennifer Connor: sometimes sometimes yes, sometimes no. Where are you in that continuum?

181

00:26:41.250 --> 00:26:41.920

Jennifer Connor: Hmm.

182

00:26:43.180 --> 00:26:50.150

Jennifer Connor: so I'm pulling some quotes from our qualitative study, because I think they really illustrate. What

183

00:26:51.220 --> 00:26:53.550

Jennifer Connor: patient-centered communication looks like.

184

00:26:55.080 --> 00:27:02.709

Jennifer Connor: So the 1st quote says, the doctor looked, and she just reassured me. She told me that my circumcision wasn't all that bad.

185

00:27:02.760 --> 00:27:12.760

Jennifer Connor: I wasn't sewed all the way, so it wouldn't be that difficult. It would be easy, and it wouldn't affect me in any way. Actually, it would help me during intercourse when I do get married.

186

00:27:12.800 --> 00:27:16.660

Jennifer Connor: and that just made the decision easier to make at that point.

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00:27:16.890 --> 00:27:20.900

Jennifer Connor: So what you see here is a physician who's being very reassuring.

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00:27:21.585 --> 00:27:30.039

Jennifer Connor: She wasn't afraid to bring up the topic, even though the patient wasn't married. Which I think again.

189

00:27:30.250 --> 00:27:51.580

Jennifer Connor: some times people would assume. Well, this isn't relevant to you because you're not married. But it may be because she might be having some urinary issues, or or she might be having trouble passing menstrual blood. So she th. This position kind of reassured her, and made her feel like I'm here with you, and I'm a partner.

190

00:27:53.216 --> 00:28:12.959

Jennifer Connor: The next one. The doctor mentioned deinfibrillation to me, and he gave me a choice to either to be deinfibrillated or to not be deinfibrillated, but he did not give me the option to do that, or he sorry he did give me the option to do that. I refuse to do it because of the pain, and she's referring to fear of pain caused by the the procedure.

191

00:28:13.020 --> 00:28:17.649

Jennifer Connor: I do not want to go through that pain again. So this one's neutral.

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00:28:18.500 --> 00:28:19.830

Jennifer Connor: It's

193

00:28:21.490 --> 00:28:24.540

Jennifer Connor: I think maybe the physician could have

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00:28:24.800 --> 00:28:34.379

Jennifer Connor: provided her with a little more information about pain management, with the deinfibulation procedure. Because she was liking it to

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00:28:34.470 --> 00:28:42.753

Jennifer Connor: the original fgc, and it's usually not going to be quite that painful. My my understanding, anyway.

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00:28:43.960 --> 00:28:48.890

Jennifer Connor: So neutral. Not necessarily good or bad, but

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00:28:50.240 --> 00:28:54.630

Jennifer Connor: you also don't get the sense like in the 1st quote, that he was there partnering with her.

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00:28:54.940 --> 00:29:14.540

Jennifer Connor: and then the last one, the 1st doctor that I saw. She could not understand what happened to me, so she called another doctor who's Egyptian and knew about this. The doctor explained to the other doctor what was done to me, and what circumcision was, and

she still didn't believe that it was the real thing. She was shocked. She's a white doctor who had never seen circumcised women before.

199

00:29:14.540 --> 00:29:29.431

Jennifer Connor: She suggested that I should have an ultrasound, but the other doctor explained to her what it was. And so I think it's clear when you read that kind of the problem. Right? Is that in that moment she felt stigmatized and othered.

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00:29:30.750 --> 00:29:42.060

Jennifer Connor: The doctor didn't hide that she didn't. I mean not that she should hide, that she didn't know. But she didn't hide her reaction. And she clearly hadn't learned much about circumcision at that point.

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00:29:43.050 --> 00:29:54.149

Jennifer Connor: So when you put those 3 together, it suddenly becomes quite clear. Kind of what? How does this look different. How do I center the patient versus othering the patient?

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00:29:59.230 --> 00:30:01.672

Jennifer Connor: I wanna, I wanna say that

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00:30:02.910 --> 00:30:16.389

Jennifer Connor: in the transcripts there were more positive stories about healthcare than negative. And so I think that's important, because the research tends to look for how do we solve problems? And so they don't always uplift those those positive experiences, too.

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00:30:17.840 --> 00:30:39.719

Jennifer Connor: and so I want to just share one more. I've heard so many stories about certain doctors who honestly don't know anything about it, or they do know, but they don't treat you as well, or they make you feel badly about it. She, a physician, told me that she's done thousands of these procedures, and she knows about it, and it affects her people as well her country. And so that made me even more comfortable to go with her

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00:30:41.395 --> 00:30:44.320

Jennifer Connor: so in that quote, you can see that

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00:30:44.390 --> 00:30:46.420

Jennifer Connor: the physician

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00:30:47.810 --> 00:30:49.929

Jennifer Connor: helped her feel less alone

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00:30:50.020 --> 00:31:09.350

Jennifer Connor: didn't make her feel like she was an odd anomaly, something like that but made her feel like, yes, I know about this. I know other women. This is. This is done in my own country. Not everyone could say that but you you certainly could say you're not alone in this right and and that.

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00:31:09.410 --> 00:31:11.060

Jennifer Connor: reassured the patient.

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00:31:11.666 --> 00:31:14.600

Jennifer Connor: But at the same time the physician didn't minimize

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00:31:14.730 --> 00:31:22.009

Jennifer Connor: what she was worried about. She made sure that she knew that I'm here to help you with whatever your concerns might be.

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00:31:22.850 --> 00:31:38.330

Jennifer Connor: One thing that strikes me with this quote and several others, is because I did. My, my 1st research, my own research project, my 1st own research project. My dissertation was about. Velvodynia provoked vestibulodynia.

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00:31:38.760 --> 00:31:39.870

Jennifer Connor: and

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00:31:40.350 --> 00:31:43.749

Jennifer Connor: I heard some similarities in the sense that

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00:31:45.050 --> 00:31:53.589

Jennifer Connor: in that study that women said, I just want a doctor, who is knowledgeable and respectful. That's what I need.

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00:31:53.660 --> 00:31:58.940

Jennifer Connor: and if I have to choose, I might choose knowledgeable with

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00:31:59.070 --> 00:32:27.490

Jennifer Connor: a bad bedside manner, if I have to choose, but I prefer both. What I think is different in the Fgc context is, you have these extra layers like. On the one hand, you have I heard over and over again from from participants and others that I've worked with, that there's an there is an appreciation for the resources in the United States. There is a a desire to learn more about preventative care.

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00:32:28.500 --> 00:32:32.519

Jennifer Connor: and how how that can be done in the Us.

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00:32:33.250 --> 00:32:34.922

Jennifer Connor: But there's also

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00:32:36.750 --> 00:32:42.240

Jennifer Connor: there's also this negative impact of the stigma and othering that can come with fgc, because.

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00:32:43.173 --> 00:32:51.869

Jennifer Connor: it's been spoken about even just the word like mutilation. That word has a stigmatizing impact.

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00:32:53.120 --> 00:32:55.250

Jennifer Connor: So in conclusion.

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00:32:58.680 --> 00:33:00.390

Jennifer Connor: sorry it's not forwarding.

224

00:33:02.610 --> 00:33:20.449

Jennifer Connor: Okay? In conclusion, I'm gonna take a quote from an article by Jacobson at all. There at robotic Canada, where they refer to the duality of anti female genital mutilation discourse, a vehicle for advocacy and stigmatization. So it's this really fine line of

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00:33:20.590 --> 00:33:23.349

Jennifer Connor: I might say I'm not

226

00:33:24.120 --> 00:33:26.150

Jennifer Connor: promoting Fgc.

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00:33:26.530 --> 00:33:38.769

Jennifer Connor: and I would be behind anyone who advocates for the end of it. But at the same time I'm going to be very, very cautious about the language that I use, so that I'm not stigmatizing

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00:33:39.470 --> 00:33:46.199

Jennifer Connor: and that that's hard to do, and it takes a little bit of of practice and knowledge and and experience.

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00:33:46.640 --> 00:33:48.635

Jennifer Connor: And then, lastly,

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00:33:49.860 --> 00:34:00.133

Jennifer Connor: that you know, having an awareness that we all bring our own perspectives to the encounters. And so, therefore, it's imperative that we seek education, that we understand.

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00:34:00.600 --> 00:34:19.604

Jennifer Connor: we understand the complications, but we also understand that that not everyone has complications that we reflect on our own assumptions. I referred to my own in the beginning, when I said I went to Catholic school, and therefore sometimes I make leaps about religion and sexuality, and I'm not even aware I'm doing it.

232

00:34:21.710 --> 00:34:38.950

Jennifer Connor: so this is where team science helps, because someone can call me on it and then, of course, that we listen and we communicate respect. And so I think it really comes down to those 5 things. Education. Reflect on your own assumptions and understand what they are. Listen and communicate respect.

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00:34:40.500 --> 00:34:46.309

Jennifer Connor: Sorry. That's 4. Okay, alright. So I have resources in the slide

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00:34:46.489 --> 00:35:06.539

Jennifer Connor: in terms of like, how do you do a deinfibulation resources you can use with patients? And I have references. But I'm gonna during the question and answer, I'm gonna pause and leave I forgot to say that a lot of things that I'm seeing today are paraphrases of a very large team of people, and so I'm going to leave their names up on the side.

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00:35:10.660 --> 00:35:11.540

Jennifer Connor: Thank you.

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00:35:12.810 --> 00:35:36.800

Ana Núñez MD: Connor. Thank you. So we have a number of questions. I'll just share with you that you know it's interesting in terms of as we talk about this in Philadelphia, in terms of our center for women's health. Pelvic floor disorders. Were a thing that lots of people had. But most people didn't talk about, and lots of health care providers, including physicians, didn't really know much about

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00:35:36.800 --> 00:35:53.990

Ana Núñez MD: in terms of doing that, and the same assumptions of patients don't want to talk about it until you talk about it, and then they actually do want to talk about it. And it's it's our stuff rather than the patients, and so our ability to communicate and not make those assumptions in terms of both, you know, advocating but recognizing

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00:35:54.382 --> 00:36:14.380

Ana Núñez MD: that there are lots of sort of cultural stigma, be it pelvic floor disorders or Fgc, that sort of play, a role that prevent potentially overcoming sort of barriers in health. So our 1st question is, what age is? Fgc, does it typically occur? Pre adolescent, adolescent or young, adult.

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00:36:15.690 --> 00:36:22.909

Jennifer Connor: So I I can answer that question confidently. And and the Somali population that is typically between 5 and 8.

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00:36:23.310 --> 00:36:30.229

Jennifer Connor: I know that in that's not true of every country. So, for example, I believe, Nigeria

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00:36:30.697 --> 00:36:33.320

Jennifer Connor: it's more common in late teens.

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00:36:33.680 --> 00:36:41.519

Jennifer Connor: And like, I said, there's 30 different countries. So, you know, I think there's going to be a variation across those 30 countries.

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00:36:41.880 --> 00:36:44.190

Jennifer Connor: but usually childhood to teen years.

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00:36:45.990 --> 00:37:10.530

Ana Núñez MD: And and I guess, sort of the the corollary that one of our questions that got sent in advance as in any practice consent. Is something that we sort of focus on. So if Fgc is a cultural practice, be helpful to understand what the consent process is like. Is there a choice? Is it done without consent, and considered to be abusive? Great, to understand more? Thank you.

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00:37:11.089 --> 00:37:17.800

Jennifer Connor: All the above kind of thing. So I think that sometimes,

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00:37:20.390 --> 00:37:21.850

Jennifer Connor: so so

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00:37:21.910 --> 00:37:23.149

Jennifer Connor: often it's

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00:37:23.190 --> 00:37:29.010

Jennifer Connor: often fgc is done by a local practitioner who's not medically trained.

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00:37:29.100 --> 00:37:36.560

Jennifer Connor: And so they're not necessarily thinking about consent. Maybe the same way a physician in in like in the Us. Would think

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00:37:38.420 --> 00:37:39.620

Jennifer Connor: so.

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00:37:40.480 --> 00:37:43.179

Jennifer Connor: but in terms of consent, more broadly.

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00:37:44.120 --> 00:37:51.219

Jennifer Connor: it isn't uncommon for a young girl to, especially if she's in a

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00:37:52.770 --> 00:37:59.619

Jennifer Connor: in a village or neighborhood, where all of her friends are also being circumcised for her to also

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00:37:59.830 --> 00:38:02.940

Jennifer Connor: ask to be circumcised. And then there's

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00:38:03.070 --> 00:38:05.780

Jennifer Connor: many different stories, as well of

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00:38:06.260 --> 00:38:11.780

Jennifer Connor: young girls or women who did not ask and fought and

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00:38:12.880 --> 00:38:27.960

Jennifer Connor: and sometimes family members are fighting with each other about whether or not it's okay. And and one family member will take the girl off somewhere unbeknownst to the other family members. So there's there are issues related to consent. Without a doubt.

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00:38:28.600 --> 00:38:40.860

Ana Núñez MD: So all of the above. Yes, no, not clear right, but also in terms of that. It is. Is it? Is it fair to say, more likely than not, it is not done by folks that are in sort of a healthcare setting.

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00:38:41.320 --> 00:38:47.189

Jennifer Connor: Right. I think I think a couple of countries that's different. I think Egypt has a lot more hospital based.

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00:38:48.395 --> 00:38:49.490

Jennifer Connor: But

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00:38:50.440 --> 00:38:58.554

Jennifer Connor: most countries is less likely to be. But that's changing as a whole. Other bioethics conversation of is that it

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00:38:59.140 --> 00:39:08.586

Jennifer Connor: it? That that there's this change of well, if we do it in a hospital or or in a clinic. Then it's okay.

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00:39:09.000 --> 00:39:10.300

Jennifer Connor: So

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00:39:11.070 --> 00:39:15.409

Jennifer Connor: yeah, there's something else you said that I wanted to. Well, I'll think of it.

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00:39:16.090 --> 00:39:31.350

Ana Núñez MD: Okay? So there's a question about speaking to the absence of members from the Somali community in this conversation. Participated research needs, you know community presence. How can a venue or talk improve community presence when speaking about them, that it impacts them? If they're not sort of there.

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00:39:31.860 --> 00:39:34.920

Jennifer Connor: Yeah. So I think that

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00:39:36.635 --> 00:39:37.520

Jennifer Connor: I

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00:39:38.130 --> 00:39:41.210

Jennifer Connor: I am careful to always invite

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00:39:41.470 --> 00:39:43.999

Jennifer Connor: presence and also

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00:39:44.310 --> 00:39:49.421

Jennifer Connor: not coerce presence, most of the time

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00:39:50.730 --> 00:39:58.249

Jennifer Connor: our Somali researchers have asked to not be involved in the presentations, or after the presentation

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00:39:58.260 --> 00:40:10.959

Jennifer Connor: said that was really stressful. I don't think I want to do it again. And so that's an important piece to understand that. All of our, all of our papers, and all of the things that are done behind the scene always have

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00:40:11.030 --> 00:40:21.839

Jennifer Connor: Somali voices. But in regards to standing up and talking about the topic, it's a really, it's it's challenging for anyone to talk about this topic in terms of it's very sensitive

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00:40:21.870 --> 00:40:35.230

Jennifer Connor: and there are different consequences for me versus someone who is from the Somali community getting up and and sharing some of the things that we talked about and interviewed people about.

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00:40:36.665 --> 00:40:37.010

Jennifer Connor: So.

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00:40:37.010 --> 00:40:48.443

Ana Núñez MD: In terms of sort of allyship versus sort of you know. Sort of objectification in terms of individuals. Sort of how do we hit that balance in terms of being able to

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00:40:48.790 --> 00:40:56.029

Ana Núñez MD: by sort of engagement, be able to present that voice. And again, I'll sort of share with you that

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00:40:56.303 --> 00:41:20.370

Ana Núñez MD: back in Philadelphia when we had some pelvic floor disorders, you know. Not everybody raised their hand. Yes, I'd like to be in a panel, so people would think about that. Some would, but sort of in terms of different level of engagement, so certainly wonderful to have that opportunity, and absolutely critical in terms of the work, to have that voice together in terms of moving that forward, but also being respectful in terms of you, know how how fun it is to do a presentation

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00:41:20.410 --> 00:41:22.720

Ana Núñez MD: for most people in terms of these things.

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00:41:23.122 --> 00:41:47.670

Ana Núñez MD: So we have another question from an individual who said that they're from a culture and religious background while female circumcision is practiced. They haven't noticed any or been experienced any negative outcomes, but they are aware of the serious complications. Ptsd infection, trauma, depression, low self esteem, uncontrollable, bleeding, sexually transmitted illnesses and said, basically, in their 15 years.

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00:41:47.670 --> 00:42:05.579

Ana Núñez MD: healthcare delivery. They've actually seen those complications without any female circumcision and seen people with female circumcision who were just fine. So you know, cause effect, correlation. I think the question is, how are those things related. What do you think.

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00:42:05.580 --> 00:42:06.120

Jennifer Connor: Yeah.

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00:42:08.990 --> 00:42:11.470

Jennifer Connor: I mean, when I look at

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00:42:11.800 --> 00:42:14.460

Jennifer Connor: the research, it's it's

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00:42:14.950 --> 00:42:21.690

Jennifer Connor: it's not always that strong to say like, it's, it's certainly because of female circumcision.

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00:42:23.430 --> 00:42:34.789

Jennifer Connor: some some research will look at, you know, within the same cultural context, uncut women and cut women. And some of those studies find a difference, and some do not.

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00:42:34.910 --> 00:42:36.090

Jennifer Connor: And

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00:42:36.220 --> 00:42:39.490

Jennifer Connor: and then, in in terms of.

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00:42:39.930 --> 00:42:43.340

Jennifer Connor: you know, just speaking to the general Us. Population.

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00:42:43.920 --> 00:42:49.159

Jennifer Connor: we have a lot of sexual dysfunctions. I can speak to that easily. And

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00:42:49.850 --> 00:42:55.270

Jennifer Connor: and in. So I I didn't mention this. But in terms of our survey I would say.

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00:42:57.660 --> 00:43:08.609

Jennifer Connor: there's less sexual desire issues in our survey participants than in the general Us. Population. The one place where that's different is pain.

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00:43:08.922 --> 00:43:17.969

Jennifer Connor: And I think that makes sense, because you have a lot of nerves in your genitals. And and you know there's there's a lot of things that can go wrong when you're

294

00:43:18.589 --> 00:43:22.779

Jennifer Connor: doing any kind of procedure that involves the genitals. So

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00:43:25.030 --> 00:43:35.149

Jennifer Connor: yes, all of these issues exist at at least 11% prevalence of of vulvodynia is also present in the Us. Population, for example.

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00:43:35.190 --> 00:43:37.700

Jennifer Connor: And so whereas

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00:43:37.810 --> 00:43:47.109

Jennifer Connor: with the Fgc population more and more like, we're kind of converging on an prevalence number of about 21%. So it's higher.

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00:43:48.170 --> 00:43:58.199

Jennifer Connor: But again, it's not. It's not only women with Fgc, and we also don't know, like how many of those women with fgc, this is actually Volvodynia, right? We we don't really know.

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00:43:58.350 --> 00:43:59.200

Jennifer Connor: So

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00:44:00.480 --> 00:44:02.860

Jennifer Connor: I think that's a really important point

301

00:44:03.400 --> 00:44:04.420

Jennifer Connor: that

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00:44:04.880 --> 00:44:06.090

Jennifer Connor: that

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00:44:08.456 --> 00:44:15.410

Jennifer Connor: I'm trying to channel a sociologist on our project who would talk about this a lot and say

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00:44:15.430 --> 00:44:17.109

Jennifer Connor: that, you know.

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00:44:18.460 --> 00:44:28.950

Jennifer Connor: just like, just like women in the Us. Women have agency to go go seek healthcare, and they're having problems just like all other women.

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00:44:29.790 --> 00:44:36.129

Jennifer Connor: it's just that there's this additional layer, that kind of trips people up because they don't know how to talk about it.

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00:44:38.110 --> 00:44:50.679

Ana Núñez MD: And that feeds to another question is, Do do you either your impression, or in the literature or both? Is culture humility of healthcare workers, less on sexual issues than on medical other medical issues.

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00:44:57.840 --> 00:45:08.729

Jennifer Connor: Well, I mean, I guess I can't answer that without my own bias as a sex therapist. Yes, I think so. And and just, you know.

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00:45:10.300 --> 00:45:21.329

Jennifer Connor: being a patient who's a middle aged woman and trying to talk to people about menopause, I mean, I think I think there's so many assumptions that healthcare providers bring to those conversations.

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00:45:21.985 --> 00:45:29.599

Jennifer Connor: And they can involve ageism. They can involved on the Fgc. It it can be.

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00:45:29.620 --> 00:45:30.870

Jennifer Connor: but it can be a lot.

312

00:45:30.910 --> 00:45:31.930

Jennifer Connor: It it

313

00:45:32.770 --> 00:45:39.749

Jennifer Connor: sometimes. You see, in the quotes from the studies that people will say, I felt like the physician thought I was like.

314

00:45:39.920 --> 00:45:42.670

Jennifer Connor: you know, part of this barbaric practice, which

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00:45:42.970 --> 00:45:49.700

Jennifer Connor: is a really strong statement that I don't think you see really a lot in other

316

00:45:49.820 --> 00:45:51.680

Jennifer Connor: problem healthcare problems.

317

00:45:53.070 --> 00:46:07.859

Ana Núñez MD: Yeah, I'll I'll just share previously in terms of you know, my work sort of as a general internist, and I think the literature about like 15 years ago. I haven't looked recently. But basically, doctors in the Us. Tend to be far more reluctant

318

00:46:07.860 --> 00:46:31.029

Ana Núñez MD: in in terms of for those that are sort of in primary care, not in those that are focused on sexual health or obstetrics and gynecology, and those type of things, but in terms of sort of primary care. They tend to be much more reluctant in terms of engaging in terms of sexual health issues as compared to sort of European physicians. So there! There's still there at least used to be a gap in terms of that, and I suspect

319

00:46:31.030 --> 00:46:38.510

Ana Núñez MD: there probably is which speaks to your issue in terms of the need for education to be able to sort of understand, or at least ask questions.

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00:46:38.510 --> 00:46:57.680

Ana Núñez MD: And then we have a question. Have you seen the horror movie, the Green Inferno group of college protesters who get quote unquote kidnapped in South American tribe. They're untouched by modern society. And the quote scariest part end quote, for the female white female lead is going through Fgm. Which is a large dramatic scene. If you see it, I'm curious if you have an opinion.

321

00:46:58.310 --> 00:47:01.018

Jennifer Connor: I have not seen it, so I can say.

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00:47:02.910 --> 00:47:03.916

Ana Núñez MD: It sounds

323

00:47:06.040 --> 00:47:07.060

Ana Núñez MD: certainly

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00:47:07.380 --> 00:47:35.710

Ana Núñez MD: dramatic in terms of, you know, scary, scary sort of type of thing, sort of people that are very different. And you know, I think it speaks to the issue that issues about sexual health issues about thalmodynia affect lots of women, and that this is sort of an area that we need to know as we take care of lots of different types of women. And the only way that we can know is to ask and engage sort of how it is for them in terms of how we can improve your health.

325

00:47:35.976 --> 00:48:04.220

Ana Núñez MD: The challenge, of course, is sort of the issue of silence, that this is just how it is. And you know one of the things that you kind of mentioned. You know sexuality in terms of arousal, and things like that, and pain run in the same tracks. So you get, you know, if you have pain, you get sort of a double dose of neither in terms of sort of nasty and lots of folks, because they're embarrassed or just don't feel comfortable, or don't have a relationship in terms of their healthcare. Providers don't have a way to talk about it.

326

00:48:04.220 --> 00:48:27.170

Ana Núñez MD: And so, being able to sort of have great training, understanding, sort of the difference, and being able to engage is really really important. So patients can sort of not have to suffer in silence, and so hopefully by your work and and the work of sort of your community members in terms of being able to move this forward. We can sort of promote issues about agency that everybody can have health

327

00:48:27.190 --> 00:48:46.840

Ana Núñez MD: rather than sort of suffering in silence. So thank you so much. We appreciate all this really interesting information. Thanks for the work that you do, and and thanks for your wonderful team and your community members in terms of being able to to move the needle in terms of improving sort of our members, and I'll turn it over to Anthony.

328

00:48:51.470 --> 00:49:20.107

Dean's Lecture Series: Alright. Thank you, Dr. Nunez. I did just wanna say just for one other question. That I did see in like the QA. As far as like the resource page. If you scroll up just earlier in the chat. We do have a link to like. The presenter slides. The doctors, founders slides for today. So you'd be able to view the resources in full there. But just to kind of wrap up I do. Wanna let everybody know that a 1 question survey will appear in your browser immediately after this Zoom session concludes.

329

00:49:20.687 --> 00:49:32.989

Dean's Lecture Series: we would really appreciate it. If you would take the time just to complete this survey. This will really help get some feedback as far as this presentation, and to inform potential topics in future Dean's lecture series, events.

330

00:49:33.286 --> 00:49:51.350

Dean's Lecture Series: and just as a reminder that this session was recorded and that will be shared out within 2 days to everybody who registered for the event. Otherwise, if you do want to take a look at the recording and re-watch the presentation, it will also be available under the education and training tab of our Ode or Odei website.

331

00:49:51.695 --> 00:50:06.759

Dean's Lecture Series: and then finally, just as a little preview as we're looking ahead to September. We do want you all to just kind of save the date, as our next team lecture Series session will be on September 11, th with our own Odi's joy, Harkin, who will be discussing restorative justice practices.

332

00:50:06.840 --> 00:50:14.210

Dean's Lecture Series: So once again, we want to thank everybody for joining, and especially thank you, Dr. Connor. For just sharing your expertise with us today.

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00:50:14.240 --> 00:50:16.030

Dean's Lecture Series: Have a good rest of your day. Everybody.