Cutting slack and cutting corners: an ethical and pragmatic response to Arora and Jacobs' 'Female genital alteration: a compromise solution'

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INTRODUCTION

Arora and Jacobs recommend a tidy way of respecting the desire of certain communities to perpetuate the tradition of altering the genitals of girls and women while ensuring that those girls and women do not experience changes in genital function or morphology. They propose that a minimal procedure, resulting in no long-term medical complications, be legalised in order to prevent more extreme and damaging forms of alteration. Their definition of a minimal procedure is determined not by the details of the procedure itself, but by its effects. A 'minimal procedure' is one that 'does not have a lasting effect on morphology or function if performed properly' (pp.9–10) or one that results in minor morphological changes which do not adversely affect sexual satisfaction or reproduction. Permissible procedures therefore include: small incisions in the clitoral hood or in the labia, or minor surgical resection of the clitoral hood or of the labia.

Their compromise stems from a desire to respect two seemingly competing legitimate interests. First, they wish to avoid ethnocentrism in their assessment of female genital alteration (FGA)[i] by challenging the blanket criminalisation. They point out that male circumcision is widely practiced, with little or no critique. Second, they wish to challenge and limit the more extreme, dangerous and oppressive forms of FGA.

In this response I argue that (a) Arora and Jacobs should not rely on the legitimacy of male circumcision in order to devise a parallel procedure for FGA, and (b) assuming that the ritual, rather than functional, aspects of FGA are more determinative does not adequately capture the rationale for performing the procedure.

MALE CIRCUMCISION: A QUESTIONABLE YARDSTICK

Arora and Jacobs assume that male circumcision (ie, excision of the foreskin) is an acceptable practice and take this as a premise in their argument, which proceeds to claim that any society which tolerates male circumcision (as all states do) ought also to permit procedures for female children whose levels of harm are comparable. While the second part of this contention seems fair, it is not at all clear that male circumcision is an acceptable practice to be taken as a yardstick for tolerable levels of harm.

Despite the authors' contention, male circumcision does not confer clear medical benefits; rather, its purported benefits remain tenuous and contested. The authors' bias here is presumably towards the findings of US-based organisations such as the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC), both of which positively promote male circumcision, against the backdrop of the entrenchment of this practice within US culture. This view is not shared by other medical bodies in similar advanced medical contexts in the West. A recent AAP report was contested by a group of European physicians.[1] The British Medical Association maintains its stance that there is insufficient evidence to support circumcision as prophylaxis.[2] Regardless of how the evidence is interpreted, all of the purported benefits of circumcision may in any case be delivered (more reliably) using vaccines, antibiotics and condoms. Arora and Jacobs are therefore better off defending male circumcision as they do minimal FGA, for cultural reasons.

The foreskin is a richly innervated, highly mobile piece of tissue that plays an important mechanical role in masturbation and in other sexual acts. Unsurprisingly then, circumcision has been shown to limit the sexuality of boys and men.[3] As such, circumcision cannot be equated with versions of FGA which remove no tissue, or those which remove tissue but without any demonstrated effect on sexual satisfaction. Male circumcision seems to equate more readily with clitorectomy, which Arora and Jacobs rightly deem to be problematic.

Consider the programme of making a 'nick' in the clitoral hood of female adolescents that was carried out at the Haborview Medical Center in Seattle in 1996. Arora and Jacobs speak approvingly of this as an archetype of their *de minimis* FGA. The removal of the foreskin is categorically a more severe and morally troublesome procedure than this. A small cut does not entail a removal of tissue, ought not to affect sexual function and is not easily visible, so that the religious/cultural signifiers it evokes need not be branded upon the person, who may change her mind about associating with those signifiers in adulthood. Further, infants and adolescents have different capacities for consent. Haborview's practice of leaving nothing but a small scar on the bodies of *adolescent* girls cannot be equated with the widespread removal of a noticeable piece of tissue from the bodies of male *infants*.

A PRAGMATIC CONCERN

Arora and Jacobs do not consider the likelihood of FGA-practicing communities adopting minimal FGA procedures as a substitute for procedures with more extreme morphological and functional effects, such as infibulation or clitorectomy. Yet without demonstrated potential for uptake, their recommendation risks irrelevance. Further, their characterisation of the procedures, in terms of ritual rather than function, is not compatible with the justifications for performing the procedure to start with.

Morphological change is not merely a contingent feature of the ritual of FGA; it is, in many cases, the purpose of the ritual. Verifiable morphological change *is* expected, and the same is often true of functional change. Some communities report aesthetic reasons for preferring genitals that are altered to be smooth and minimal, deeming them to be more hygienic.[4] Changes to sexual satisfaction are also, in many cases, intended. According to a recent ethnography in Egypt,[5] where FGA prevalence stands at 91%, behind only Somalia, Guinea and Djibouti,[6] the main reason for performing clitorectomy is 'to reduce and regulate

[i]In consideration of this concern, they urge interlocutors to switch to the term 'female genital alteration' instead of the more common 'female genital mutilation'. For consistency, I adopt this convention here.

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girls' and women's sexual desires and sexual drive' (p. 184), based on a conception of the clitoris as a site of uncontrollable sexual compulsion, in a culture in which women's virginity and fidelity are prized. In Somalia, FGA ensures religious adherence; in Nigeria, the clitoris is believed to pose a threat in childbirth. Satisfying these reasons often requires complete clitoral excision or infibulation. Since obtaining these changes is the very reason for performing the practice, Arora and Jacobs' suggested replacement procedure would miss the mark.

By contrast, the practice of 'sunat perempuan' in Muslim Malay regions of South-East Asia (typically in parts of Thailand, Indonesia and Malaysia) customarily consists merely of pricking or scratching the clitoris of female infants to draw a small drop of blood, followed by disinfection.[7] In most cases, this minimal version of FGA simply marks the infant's entry into the community, and 'sunat lelaki' (male circumcision) satisfies the same function. Such practices are functionally no different to piercing a young child's ears, which is a common practice in other cultures (eg, the Hindu practice of 'karnavedha').

The effect of legalising minimal FGA would presumably mean that some communities would be able to practice their varieties of FGA legally, while others would continue to practice theirs illegally, since the minimal version on offer does not bring about the required changes any more than piercing the child's ear would. This is concerning since the latter were presumably the original target, as their versions of FGA have more problematic rationales, are a good deal more dangerous and are more likely to result in complications.

More importantly, in accounting for FGA as only a rite of passage, Arora and Jacobs neglect to consider the function it plays in particular cultures, in which the prevalence of FGA is high. These functions vary considerably, to the extent that FGA-practicing communities may have little else in common beyond this practice. This privileging of the ritual over the functional may reveal an underlying attitude that many hold towards FGA as a practice of the 'other': that it is merely an irrational hoop-jumping exercise without an internally consistent logic, which may be radically transformed (into a much more minimal version) while somehow maintaining its ritual power. FGA is practiced for reasons that are perfectly rational within its host cultures, and it is often performed in order to bring about a discernible change in appearance and function. Whatever one's moral view on these logics, Arora and Jacobs' analysis assumes their triviality, which is itself morally questionable.

That said, cultural practices are of course changeable, and at their base, often guided by pragmatism. Perhaps the availability of a legal process in which a small incision is made, with no tissue removal, in a sterile environment, by a trained and experienced professional, with the possibility of follow-up should there be any complications and perhaps even with the possibility of formal certification, would convert communities or individuals having a preference for more extensive forms of FGA, but willing to be persuaded by legality, availability and safety.

This still leaves open the question of why Arora and Jacobs do not take this opportunity to also recommend a minimal version of male circumcision, in which male infants are subject to a small cut in the foreskin, which heals to a scar with no morphological or functional changes. Indeed, it is interesting to note that pre-Hellenistic Jewish circumcision involved the removal of only a small part of the prepuce, so that there is perhaps as much historical variability in this practice as there is in FGA.

CONCLUSION

It seems strange to be concerned only with establishing the case for *de minimis* FGA, and to centre this case on the acceptability of a procedure that is more severe than the one being suggested! The *de minimis* suggestion would be more appealing if it applied to all non-therapeutic genital surgeries on persons who are too young to consent, rather than simply to FGA; that is, one could rule that all forms of non-therapeutic alteration of a child's body are illegal if (in the absence of complications) they cause morphological or functional changes. In that case an important message would be sent out: rites of passage are important to all of us, but one must not cause irreversible changes to the body of another person without their consent.

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