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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Permit female genital ‘nicks’ that respect culture/religion but don’t harm, say experts

Compromise needed to protect young women from more serious forms of genital cutting

A small surgical ‘nick’ or minimalist procedures that slightly change the look, but not the function or sensory capacity of a young woman’s external genitalia, should be legally permitted as a compromise solution to the vexed issue of FGM, argue gynaecologists in the ***Journal of Medical Ethics.***

This more nuanced approach would uphold cultural and religious traditions without sacrificing the health and wellbeing of girls and young women, contend the US authors.

Despite 30 years of campaigning, the practice of cutting women’s genitalia continues to flourish in many African countries and in immigrant African communities elsewhere. To date, attempts to stamp it out with legislation have failed, and may instead be driving it underground, they suggest.

“We are *not* arguing that *any* procedure on the female genitalia is desirable,” they emphasise. “Rather, we only argue that certain procedures ought to be tolerated by liberal societies.”

To begin with, the term ‘female genital mutilation’ (FGM) should be replaced with the less emotive ‘female genital alteration’ (FGA) to reflect the different types of procedure and their associated risks, and to minimise ‘demonisation’ of important cultural practices, they say.

FGM is not an appropriate term to use for the type of procedures they advocate, which are akin to cosmetic dentistry (orthodontics), breast implants, or the type of vaginal lip sculpting (labiaplasty) “for which affluent women pay thousands of dollars,” they insist.

Current categorisation covers four types of female genital cutting, with type IV the most invasive and dangerous. But the authors call for a new system of categorisation that is based on the effects of the procedure rather than the process.

Category 1 would include procedures that should have no long lasting effects on the appearance or function of the genitalia, if performed properly: an example would be a small nick in the vulvar skin.

Category 2 would include procedures that change the appearance slightly but which are not expected to have any lasting effects on reproductive capacity or sexual fulfilment. Examples include pulling back the hood of the clitoris and labiaplasty.

Categories 3-5 would include procedures, such as clitoris removal and vaginal cauterisation that maim or harm and impair sexual fulfilment, pregnancy and childbirth. These should be banned, they say.

Categories 1 and 2 are no different to male circumcision, which is rarely performed for therapeutic benefit, but which is tolerated and legal in liberal societies, the authors argue.

And restricting these categories of FGA is “culturally insensitive and supremacist and discriminatory towards women,” they contend.

Rather, permitting this compromise would better protect girls and young women from the long term harms of the more severe forms of female genital cutting, they suggest.

“In order to better protect female children from the long term harms of categories 3 and 4 of FGA, we must adopt a more nuanced position that acknowledges that categories 1 and 2 are different in that they are not associated with long term medical risks, are culturally sensitive, do not discriminate on the basis of gender and do not violate human rights,” they conclude.

But in one of a series of commentaries in response to this paper, Professor Ruth Macklin of Albert Einstein College of Medicine, New York, insists that there is no parity between categories 1 and 2 FGA and male circumcision.

“That may be true regarding the degree of harm the procedure causes, but it is not true of the origins or the continued symbolic meaning of FGA as a necessity for being an ‘acceptable woman',” she explains. “There is no doubt that in whatever form, FGA has its origin and purpose in controlling women.”

And she concludes: “Cultural change proceeds slowly. But with strong support from non-governmental organisations, especially those comprising local and regional women, a cultural tradition designed to control women—even in its least harmful form—is best abandoned.”

In another commentary, Brian D Earp, visiting scholar at the Hastings Center, Bioethics Research Institute in New York, argues that permitting minimalist FGA would generate a litany of legal, regulatory, medical, and sexual problems, leading to “a fiasco.”

Rather than continuing to tolerate male circumcision, and using this as a benchmark for allowing ‘minor’ forms of FGA, it may instead be time to consider taking a less tolerant stance towards both procedures, he says.

“Ultimately, I suggest that children of whatever sex or gender should be free from having healthy parts of their most intimate sexual organs either damaged or removed, before they can understand what is at stake in such an intervention and agree to it themselves,” he writes.

In a further commentary, Dr Arianne Shahvisi, of the Department of Ethics at the University of Sussex, says that a minimalist approach to FGA is unlikely to fulfil the intentions of the procedure—to change the aesthetic appearance of the female genitalia, and to control women’s sexual appetites.

And she wonders why the authors don’t take the opportunity to recommend a more minimalist approach to male circumcision.

“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,” she writes.

Finally, in a linked editorial, Dr Michael Dunn, of the Ethox Centre, University of Oxford, points out “The main argument is controversial, but its airing on the pages of the journal has a clear purpose: by subjecting FGM in its many forms to ethical analysis, we will be in a stronger position to develop and tailor interventions that function to prevent indefensible practices of this kind.”

The evidence suggests that at least 200 million girls and women alive today have been subjected to genital cutting, he says.