COMMENTARY

Ethical concerns in female genital cutting

Rebecca J. Cook

Description

An initial ethical concern is what properly to call what the World Health Organization (WHO) describes as:

> all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.[1]

A name commonly applied, including by the WHO itself, is "female genital mutilation" but this description may be ethically inappropriate. Descriptively, the word "mutilation" may be exaggerated, because it fails to distinguish between the four types of genital cutting recognized by the WHO. Evaluatively, the name is not a neutral description but a severely hostile judgment, since it condemns those who seek, authorize and perform such cutting as mutilators of human beings. Culturally, the name is disrespectful, because it fails to respect the motivation with which those who request the procedure for their daughters are acting. Personally, the name is again disrespectful, because it tells women who were subjected to procedures that they have been mutilated, by their parents or other family members. Among communities in which the practice has prevailed, it is described by the word that signifies purification.[2] Purity in some communities is a condition for a young girl's marriage, which is essential for daughters' future where single women have no opportunities. A WHO study critical of the procedure has conceded that:

> in a society where there is little economic viability for women outside marriage, ensuring that a daughter undergoes genital mutilation as a child or teenager is a loving act to make certain of her marriageability.[3]

This recognition separates harms resulting from the procedure from intentions of parents who seek it. Accordingly, they should not be described as mutilators of their children. More ethically sensitive language, such as female genital cutting (FGC), favours description over evaluation and personal condemnation.[4]

Types and Extent

The WHO has distinguished four types of FGC, with some possible overlap in categories but ranging from the minor to the more severe. They are:

Type I – Excision of the prepuce (equivalent to the male foreskin) with or without excision of part or all of the clitoris;

Type II - Excision of the prepuce and clitoris together with partial or total excision of the labia minora;

Type III - Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);

Type IV - Unclassified: Pricking, piercing, or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding, or of herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure that falls under the definition of female genital mutilation given above.[5]

Accepting the broad coverage of these categories, it has been observed that "[w]orldwide, an estimated 130 million girls and women have undergone (FGC). At least two million girls a year are at risk of undergoing some form of the procedure".[6] Further, under the impact of immigration, the practice is now found in regions where it has not been prevalent. It has been noted that FGC

> is practiced in 28 African countries in the sub-Saharan and Northeastern regions…However, prevalence varies widely from country to country. It ranges from nearly 90 percent or higher in Egypt, Eritrea, Mali and Sudan to less than 50 per cent in the Central African Republic and Côte d'Ivoire, to 5 per cent in the Democratic Republic of Congo and Uganda …Women who have undergone FGC are also found among African immigrant communities in Europe, Canada, Australia and the United States.[7]

Consequences

Ethical concerns are raised not simply from the inherent bodily insult of FGC, which ranges from minor cuts to major procedures, the more invasive of which, such as infibulation, have caused all forms of FGC to be characterized as mutilation, but from its known consequences. Some harmful effects are due to the extent of interventions, but even more minor procedures can prove damaging, health-threatening, and not uncommonly life-threatening when conducted with crude instruments, in unhygienic, non-sterile conditions, and without anesthesia.

Milder forms of Type IV FGC and minor forms of Type I, though presenting inherent risks, often from non-sterile practice, allow relatively speedy recovery and unimpaired urination, menstruation and sexual intercourse in later years. In many settings, FGC is usually undertaken when girls are young. However, it is found that

> [g]irls are commonly circumcised between the ages of 4 and 10 years, but in some communities the procedure may be performed on infants, or it may be postponed until just before marriage or even after the birth of the first child.[8]

Ethical concerns over parental use and misuse of authority over their dependent children, affecting the children's health, are often reduced when adolescents and adults reach capacity for autonomy. However, even autonomous adults can be subject to family and social pressure to agree to procedures they disfavour and reasonably understand as liable to prejudice their health, such as FGC, so that their capacity for freely given consent is negated or compromised.

All types of FGC present the risk of immediate and often longer-term health complications, including psychological pain-related effects. The more immediate medical complications include excessive bleeding, which may necessitate emergency medical care that is not always available. Serious sepsis may occur, particularly where unsterile instruments are employed for even minor cutting, and infection can lead to septicemia if the bacteria reach the bloodstream, which can be fatal. Acute urine retention can also result from the wound becoming swollen and inflamed.[9] The most severe long-term complications arise with FGC Types II and III. Common complications of infibulation include repeated urinary tract infection

and chronic pelvic infections, which may cause irreparable reproductive organ damage and infertility. Excessive growth of scar tissue may result, which can be disfiguring, and cysts (implantation dermoids) may also occur. Complications of pregnancy include difficulties before, during and after delivery,[10] such as pain during and following deinfibulation. Infibulation-related complications can arise in early labour, and from prolonged and obstructed labour, including creation of obstetric fistulae, which can have devastating effects in women's domestic circumstances and family lives.[11]

Fetal distress and stillbirth or early neonatal death may result, fetal deaths apparently being related to obstruction of delivery presented by vulva scarring in Type III procedures or the extra scarring sometimes associated with complicated Types I and II procedures.[12] Postpartum hemorrhage is significantly more common in women with FGC, usually associated with scarring that may result from all types of FGC, and scarring can contribute to and even cause maternal death, often resulting from unattended or improperly treated obstructed labour.[13]

Contexts

In view of the risks and harmful consequences that societies in which FGC is prevalent know to be associated with and often directly due to the practice, its continuing acceptance and even requirement raises the ethical question of why the practice persists. One explanation is religiosity, since the practice has historically been followed out of a sense of devout duty in Islamic, Christian and Jewish communities, although nothing in the sacred texts or doctrines of these religions mandates it, unlike male circumcision in Islam and Judaism. Another explanation is the cultural requirement of female purity, exhibited in the virginity of brides and fidelity of wives. A family's females are the focus and token of its honour, so that females are guardians of their families' virtue. Females' sexual enterprise, or their sexual violation, robs their families of honour, status and respect in their communities. The purpose of FGC, especially Types II and III, is to reduce the female drive for sexual satisfaction, and reduce their vulnerability to rape. This explanation reflects gender stereotyping, which enhances men's reputations if they are sexually adventurous, but condemns women for sexual immodesty or being sexually provocative or experimental.

This explanation fits into a wider framework of male hostility to females exhibiting or indulging their sexuality. In the latter half of the 19th century in Europe, including the U.K., and in the United States, gynecological surgeons performed many clitoridectomies, on what were claimed to be medical indications for conditions related to sexual disorder, such as hysteria, epilepsy, melancholia, the psychiatric disorder of nymphomania, and the psycho-social disorder of seeking or deriving pleasure from sex.[14] By this explanation, FGC appears to be continuation of a history of social control of female sexuality, a feature of many traditional societies of various religious faiths. Consistently with this explanation, the practice has been seen to decline among daughters of urban, educated women, and, for instance, among Ibo girls in Nigeria, largely attributed to the rising rate of women's formal education.[15]

Professional Responses

Choice of ethical response among physicians brings out the ambivalence of the historical medical ethic, Do No Harm. In the language of modern bioethics, this is embodied in the principle of non-maleficence. FGC is no doubt safer in medical than in unskilled hands, so that, for instance, excessive bleeding can be better contained, but at best the procedure bears an irreducible minimum risk of injury, and in almost all cases is demonstrably non-therapeutic. A direct application of the Do No Harm principle therefore indicates that physicians should not undertake FGC. Another aspect of non-

maleficence, however, is to minimize harm. The case for medical involvement is that when parents feel compelled to have FGC for their daughters, and unskilled practitioners such as family members are available to undertake procedures in non-sterile conditions and by crude means, harm will be minimized if physicians agree to conduct procedures and can do so by minimally invasive means.

There is strong medical professional objection, however, to seeming to medicalize FGC, and to making it appear to be part of the legitimate practice of medicine. The objection is analogous to physicians' non-participation in judicially-ordered amputation, corporal or capital punishment, and governmentally permitted torture. For instance in 1994, the General Assembly of the International Federation of Gynecology and Obstetrics resolved that gynecologists should "oppose any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals."[16] Accordingly, practitioners should not succumb to inducements, threats of unskilled alternatives, or manipulation, to give the esteem of their medical professional status to FGC. This prohibition is reinforced by the ethical codes of many national medical associations, and by an increasing number of national laws, several of which are vigorously monitored for compliance. Underpinning these is the UN Convention on the Rights of the Child, ratified by all countries of the world except Somalia and the U.S. Article 19(1) requires that all states apply "measures to protect the child from all forms of physical or mental violence, injury or abuse," and Article 24(3) requires abolition of "traditional practices prejudicial to the health of the child."[17] Harmful traditional practices may change under the impact of internationally respected human rights principles.[18]

A key role of physicians requested to undertake FGC is to explain why they cannot, and to educate requesting parents and others about risks of procedures in unskilled hands, and the violation of women's bodily integrity due to these practices. Physicians can also explain decline in use of the practice, and that it is decreasing as an expectation in more educated communities. It may also be essential to point out, where laws prohibit FGC, that its performance is an offence[19] and its very request bears risks of legal liability. Physicians' responses may give less emphasis to punitive aspects of FGC, however, than to aiding parents, families and communities to understand the protective purpose the medical profession advances in eliminating such procedures. Medical associations and individual physicians are also urged to collaborate with national authorities, non-governmental organizations and, for instance, religious leaders, to support measures aimed at elimination of this harmful traditional practice.[20]

Notes

1. Department of Women's Health, Family and Community Health, WHO. A systematic review of the health complications of female genital mutilation including sequelae in childbirth. WHO/FCH/WMH/00.2. Geneva: World Health Organization, 2000, p.11.
2. L. Brown (editor). The New Shorter Oxford English Dictionary. Oxford Clarendon Press, 1993, p. 405.
3. N. Toubia, S. Izett. Female genital mutilation: an overview. Geneva: World Health Organization, 1998, p. 2.
4. R.J. Cook, B.M. Dickens, M.F. Fathalla. Female genital cutting (mutilation/circumcision): ethical and legal dimensions. International Journal of Gynecology and Obstetrics 2002; 79: 281-7.
5. Note 1 above, p. 11.
6. A. Rahman, N. Toubia (editors). Female genital mutilation: a guide to laws and policies worldwide. London and New York: Zed Books, 2000, p. 6.
7. Ibid., p. 7.
8. N. Toubia. Female circumcision as a public health issue. New England J. Medicine 1994; 331: 712-716 at p. 712.

9. Note 3 above, p. 26.
10. Note 1 above, p. 11.
11. R.J. Cook, B.M. Dickens, S. Syed. Obstetric fistula: the challenge to human rights. International Journal of Gynecology and Obstetrics 2004; 87: 72-7.
12. Note 1 above, p. 51.
13. Ibid., p. 48.
14. M.F. Fathalla. The girl child. International Journal of Gynecology and Obstetrics 2000; 70: 7-12.
15. P.O. Nkwo, H.E. Onah. Decrease in female genital mutilation among Nigerian Ibo girls. International Journal of Gynecology and Obstetrics 2001; 75: 321-2.
16. Resolution in Female Genital Mutilation, FIGO General Assembly, Montreal, Canada, 1994. See note 14 above, p. 7.
17. See R.J. Cook, B.M. Dickens, M.F. Fathalla. Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law. Oxford: Oxford University Press 2003, Case Study No. 2, pp. 262-275.
18. C.A.A. Packer. Using Human Rights to Change Tradition: Traditional Practices Harmful to Women's Reproductive Health in sub-Saharan Africa. Antwerp, Oxford and New York: Intersentia 2002.
19. Note 17 above, pp. 268-272.
20. A.J. Gage, R. Van Rossem. Attitudes toward the discontinuation of female genital cutting among men and women in Guinea. International Journal of Gynecology and Obstetrics 2006; 92: 92-6.