Harm reduction and female genital alteration: a response to the commentaries

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We thank the commentators for their thoughtful remarks. We have arranged our responses to the commentators thematically; within each section we start first with general comments before discussing particular statements by individual commentators. We also thank the *Journal of Medical Ethics* for publishing our original manuscript, the accompanying commentaries, an editorial from the Journal staff, and our response together in order to facilitate dialogue surrounding the multifaceted, complex issue being discussed. Our response is confined to issues involving female genital alteration (FGA). Some of the commentators discussed male circumcision. We addressed this in the original manuscript, and again in this response only in passing, given that circumcision is legal throughout the Western world. Further discussion of the ethics of male circumcision is beyond the scope of this discussion.

We appreciate the areas of agreement between our position and the viewpoints of the commentators. Particularly, we wish to acknowledge Professor Macklin's view that sanctioning de minimis FGA would constitute a harm reduction strategy that cannot reasonably be considered a human rights violation. We also recognise that Professor Shahvisi's hypothesis of a ritual vulvar nick in a clean environment and performed by a trained provider as ethically appropriate indeed is within the scope of our category 1 procedures.[1] Professor Shahvisi mistakenly describes this suggested proposed classification system as one based on ritual, and recommends a system that instead accounts for function. In fact, our classification system (as opposed to the current WHO system that groups various FGA procedures based on ritual) is based on functional impact upon the female. Therefore, we and Professor Shahvisi agree that, for medical, ethical and policy reasons, the classification system should be revised to focus on function, not ritual.

SYMBOLIC CONCERNS

The reviewers had several comments regarding the symbolism of the compromise position on FGA regarding (1) gender oppression, (2) the corollary with male circumcision and (3) the psychosocial significance of genitalia in medicine and culture. We, like the reviewers, struggle with the reality that FGA is symbolic of gender oppression in many cultures and practices. We do not share Professor Macklin's belief that this is inseparable from all forms of the practice, and will expand on this below. We share Professor Earp's concern that adopting a compromise position may lend a cloak of respectability and set back the political progress that has been thus far made. However, FGA does not always connote or constitute gender oppression. To the extent that it may not, the compromise solution we laid out can pave the way for conversation regarding gender differentiation in a cultural tolerant and medically correct manner. Even where FGA constitutes or reinforces gender oppression, adopting our proposed classification system will refocus conversation on function and harm. Thus, even if all forms of FGA are worthy of condemnation as forms of gender oppression, blanket condemnation that equates all FGA procedures in terms of risk is inappropriate. We do not share Professor Shahvisi's worry that adopting such a compromise solution will lead to a justice issue in which some communities are able to perform their traditional FGA procedures and others are not. Those that cause serious harm should not be permitted within any cultural framework. Those that do not should not be prevented. It is precisely because we do not feel such cultural traditions are trivial, as Professor Shahvisi construes that we do, that we believe the burden of proof is on the external community to define and categorise harm rather than simply responding in ethnocentric disgust.

A second concern was in regard to the comparison of FGA with male circumcision. As Professor Earp correctly points out, one logical solution to the discrepant policy treatment of male and female ritual, non-therapeutic procedures on children is to simply eliminate both—as he would prefer. Another solution, of course, is the position that we have taken that allows for some FGA procedures that are not associated with harm, but recommends continued opposition to those that confer health risks. While we compare and contrast FGA with male circumcision, our argument does not rest on the legitimacy of male circumcision, contrary to the way in which Professor Shahvisi interprets our position. In fact, we merely pointed out in the introduction to the paper the discrepant treatment of male and FGA in contemporary Western society to provide contextual background. We respectfully disagree with the description by Earp and Professor Shahvisi regarding the purported health risks of circumcision, and have discussed our evidence-based position on the paucity of medical risks and the possibility of medical benefits elsewhere.[2] Furthermore, male circumcision anatomically and surgically equates with removal of the female clitoral hood and not with clitorectomy as Professor Shahvisi states. We agree with Professor Earp that removing the clitoral hood is much more difficult than removing male foreskin; it is probably only possible in adolescents after the pubertal transition. We also disagree with Earp's limited characterisation of the scope of the WHO's stance on circumcision. WHO discusses voluntary male circumcision of 15–49 year olds, and also broadening existing and ensuring sustainable programmes for infant and adolescent male circumcision, referring to circumcision after sexual maturity a 'catch-up' programme, and implying that an opportunity was missed.[3]

Finally, we note Professor Earp's comment regarding the psychosocial significance of genitalia versus other body parts as a component of elective or non-therapeutic surgery. As obstetrician-gynaecologists, we certainly agree that society places special importance on sexual organs. However, medically, the risks/benefits/alternatives of procedures should be compared evenly across specialties. The 'yuck factor' should not permit a discordant calculus of harm and risk.

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PRAGMATIC CONCERNS

The reviewers also noted pragmatic issues surrounding our proposed compromise solution. That is, they believed that (1) such a compromise was unlikely to succeed from a policy or practice standpoint, (2) the ability to verify adherence to the compromise solution would be difficult and (3) defining harm is subjective.

The degree to which the use of the vulvar nick as a harm reduction strategy for replacing radical alteration of the female external genitalia can only be assessed empirically. Dismissing the prospects for success of such a strategy is inappropriately defeatist, in view of the frequency of these radical procedures and the degree of harm they cause. We disagree with Professor Shahvisi that there is no demonstrated potential for success. Indeed, the Harborview example points to at least some communities existing that are open to considering such a *de minimis* FGA procedure to be adequate for their needs. We share the commentators' concerns that such a compromise might not be universally well received and that it might not succeed, especially in communities where procedures such as infibulation are endemic. However, the novel categorisation system is important both for meaningful research and advocacy, regardless of whether any headway is made in terms of improved public health. Furthermore, under the principle of harm reduction, if even a few children are spared a category 3–5 procedure and instead undergo a *de minimis* procedure, then our proposed strategy is worthwhile.

Given that these procedures are performed as a component of a cultural ceremony outside of the medical setting, it may be difficult for either medical scholars or public authorities to monitor the extent of the procedures being performed. While a procedure by a trained medical professional, such as was the case in the Harborview example and discussed by Professor Macklin, is certainly one method to handle this limitation, we do not feel that this is either practical or necessary. The fact that a slippery slope exists where more can be done either concurrently at time of a supposed *de minimis* procedure or at a later time, as stated by Professor Earp, should not prevent the correct policy being set forth in the first place. The current regulatory and advocacy positions against categories 3–5 FGA due to harm to the female should still stand.

Professor Earp cautions regarding the subjective nature of harm. We share his concern that data collection will be difficult surrounding risks of *de minimis* and all FGA procedures. However, data collection is of paramount importance as the inclusion of certain procedures as categories 1 and 2 may change if data accumulate linking such a procedure to medical harm. However, as we state above, that the ethically correct position may be manipulated or difficult to study does not change the fact that it remains the appropriate position for which to advocate. Many procedures in medicine are difficult to study for a variety of reasons—termination of pregnancy, impact of racial disparities on end-of-life care, role of physician bias in patient counselling, and so on. However, it is the role of bioethics to acknowledge these difficulties but recommend a best course of action. We also agree that the burden of proof must lie with the practitioner in demonstrating the paucity of long-term harm. While there are risks to any, even minor, medical procedure such as intravenous line insertion, many of the risks of FGA procedures are minor or unlikely to occur. Finally, we agree that methodology and quality of data surrounding FGA and its medical risks are also difficult given the topic of study (much as it is difficult to truly gauge the sexual impact of male circumcision). However, evidence-based medicine must adhere to its pre-established process of privileging high-quality data over studies of lesser methodology.

ETHICAL AND LEGAL CONCERNS

Finally, the reviewers raised several concerns regarding the ethical and legal basis for the compromise position offered. These included issues surrounding (1) consent, (2) the legal definition of criminal assault, (3) the role of the government to accommodate cultural beliefs and (4) the differences in intended policy audiences between Western nations and Africa. We agree with Professors Shahvisi and Earp that the inter-related issues of autonomy and consent are of utmost importance in the discussion surrounding FGA. As stated previously, we have laid out our responses regarding paediatric decision-making in the realm of male circumcision.[2] However, most FGA procedures are performed on adolescents. Adolescents are capable of meaningful assent. Thus, the ability of the adolescent to assent (and indeed, the mandatory nature of this assent), prior to procedure performance, is critical. We agree with Professor Earp that in general, elective procedures should be delayed from childhood to adulthood, when the individual is able to assent, and give consent as well. However, in the case of ritual procedures, it is important to remember that only considering medical benefit too narrowly construes the best interest standard for paediatric decision-making. The fact that *de minimis* FGA procedures are not associated with any long-term harm also strengthens the argument that such decisions are well within the prerogative of parents to make for their children.

Professor Earp argues that for such a compromise solution to be implemented, the laws defining criminal assault in Western nations would have to be rewritten. One of his premises, which he attributes to Blackstone without citation or context, is that laws cannot differentiate between degrees of violence. Hence, our categorisation system would be legally problematic. This premise was incorrect in Blackstone's time and is even less true now. Laws of all Western nations differentiate between degrees of violence, intent of the violence, and relationship between the perpetrator and the subject of violence in determining both the existence and the degree of criminal liability. Mass murder, a bruise incurred in a bar fight, and an injury inflicted in self-defence are not treated identically by the criminal code of any Western nation. Earp mistakenly believes that our categorisation system would require a legal carve-out. Yet, currently, since infant male circumcision is legal in every country but FGA is not in many countries, it is FGA that is already a legal carve-out. Criminal law distinguishes between degrees of violence and requires some sort of criminal intent. For example, piercing the ears of one's infant daughter is not criminal, but burning her skin with cigarettes is illegal. The intent to harm is not present in *de minimis* FGA.

Professor Earp also discusses the Jacobs Test and the role of the government to accommodate cultural beliefs. He is correct regarding the original publication,[4] as well as the subsequent revision of the test.[2] More importantly, the precise nature of the inquiry regarding the scope and limitations of the government's duty to protect minors from religious practices is the subject of an additional manuscript.[5] We appreciate that discussion of the appropriate role of some nations in influencing FGA policies in other nations involves considerations of political theory and practical statecraft that are beyond the scope of this discussion. Finally, it is important to note that we believe that this compromise solution should be broadly and equally implemented. That is, it is the Western laws that need to change, and also the advocacy positions worldwide.

The impact may be unequal given the unequal demographics of the practice, but the ethically correct position is universal.

Competing interests None declared.

Provenance and peer review Commissioned; internally peer reviewed.

To cite Arora KS, Jacobs AJ. *J Med Ethics* 2016;**42**:164–166.

Received 6 January 2016
Accepted 7 January 2016

- http://dx.doi.org/10.1136/medethics-2014-102375
- http://dx.doi.org/10.1136/medethics-2015-103027
- http://dx.doi.org/10.1136/medethics-2015-103030
- http://dx.doi.org/10.1136/medethics-2015-103206

J Med Ethics 2016;**42**:164–166.
doi:10.1136/medethics-2016-103376

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