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 ritual, and recommends a system that accounts for function, not ritual. 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 also disagree with Earp that removing the clitoral hood is 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. 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 Harbörview 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 such as intubation 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 Harbörview 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. 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. 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, as well as the subsequent revision of the test. 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. 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.

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**REFERENCES**

5. Levin H, Jacobs A, Arora KS. To accommodate or not to accommodate: (when) should the state regulate religion to protect the rights of children and third parties. *Wash Lee Law Rev* in press.