Nursing Ethics

The need for a unified ethical stance on child genital cutting

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Abstract

The American College of Nurse-Midwives (ACNM), American Society for Pain Management Nursing (ASPMN), American Academy of Pediatrics (AAP), and other largely U.S.-based medical organizations have argued that at least some forms of non-therapeutic child genital cutting, including routine penile circumcision, are ethically permissible even when performed on non-consenting minors. In support of this view, these organizations have at times appealed to potential health benefits that may follow from removing sexually sensitive, non-diseased tissue from the genitals of such minors. We argue that these appeals to "health benefits" as a way of justifying medically unnecessary child genital cutting practices may have unintended consequences. For example, it may create a "loophole" through which certain forms of female genital cutting—or female genital mutilation (FGM) as it is defined by the World Health Organization (WHO)—could potentially be legitimized. Moreover, by comparing current dominant Western attitudes toward "FGM" and so-called intersex genital "normalization" surgeries (i.e., surgeries on children with certain differences of sex development), we show that the concept of health invoked in each case is inconsistent and culturally biased. It is time for Western healthcare organizations—including the ACNM, ASPMN, AAP, and WHO—to adopt a more consistent concept of health and a unified ethical stance when it comes to child genital cutting practices.

Introduction

When or under what conditions is it morally wrong to cut a child's genitals when it is not medically necessary (see Box 1) to do so? According to the World Health Organization (WHO), all non-Western forms of medically unnecessary female genital cutting (NWFGC; see Table 1 for a detailed explanation of this terminology) constitute mutilation and violate the human right to bodily integrity (1). It does not matter whether the cutting is done for religious or cultural reasons, whether it is performed by a skilled operator using pain control or sterile instruments, which part of the vulva is affected, or whether any tissue is removed: even a "ritual nick" to the clitoral prepuce or hood that heals completely is considered a human rights violation by the WHO (2–4). At the same time, the WHO does not consider medically unnecessary male genital cutting or circumcision to be a human rights violation, even when it is done by a non-medical practitioner without pain control under unhygienic conditions and/or without the consent of the affected individual (5–8). Finally, although the WHO has referred to medically unnecessary intersex genital cutting (discussed below) as a form of "abuse" in at least one policy document (9), it has not taken an unqualified stand against such procedures, nor mobilized a global campaign to "eliminate" them as it has for NWFGC.

The moral similarities and differences between female and male genital cutting have been discussed at length in the recent bioethics literature (10–21). The present analysis will therefore focus on the comparison between female and intersex genital cutting, which has received relatively less attention [but see (22–26)].[1] Although the WHO has, in the above-mentioned policy document, brought its stance on intersex genital cutting into closer alignment with its stance on NWFGC, most Western healthcare organizations and legal regimes have not explicitly pursued such alignment. The question for this paper, then, is whether a "zero tolerance" policy for NWFGC can be coherently maintained without also adopting such a policy for medically unnecessary intersex genital cutting, without recourse to cultural or moral double standards (29).

Box 1: Defining medical necessity

According to a recent international consensus statement, "an intervention to alter a bodily state is medically necessary when (a) the bodily state poses a serious, time-sensitive threat to the person's well-being, typically due to a functional impairment in an associated somatic process, and (b) the intervention, as performed without delay, is the least harmful feasible means of changing the bodily state to one that alleviates the threat. 'Medically necessary' is therefore different from 'medically beneficial'—a weaker standard—which requires only that the expected health-related benefits outweigh the expected health-related harms. The latter ratio is often contested as it depends on the specific weights assigned to the potential outcomes of the intervention, given, among other things, (a) the subjective value to the individual of the body parts that may be affected, (b) the individual's tolerance for different kinds or degrees of risk to which those body parts may be exposed, and (c) any preferences the individual may have for alternative (e.g., less invasive or risky) means of pursuing the intended health-related benefits" (2) (p. 18). For further discussion and conceptual analysis, see (30–32).

[1] The comparison between male and intersex genital cutting has been ably discussed by Kira Antinuk in a previous issue of this journal (27). See also (28).

Consider a form of intersex genital cutting that involves surgically reducing an enlarged clitoris (clitoropenis), also known as "feminizing" clitoroplasty (33). This surgery may be pursued in the case of children with certain differences of sex development or intersex traits[2] who are assigned female at birth, so as to make their genitals appear more stereotypically feminine (37). Compared to ritual nicking, pricking, or partial removal of the clitoral hood, for example (all of which have been defined as "mutilations" by the WHO), such a practice would seem to be, if anything, far more invasive and physically risky; and it is not usually any more consensual. The ethical implications of this comparison can be reached by different routes. For example, one may pursue a utilitarian or harm-based analysis, focused on potential adverse consequences of the respective forms of genital cutting; or, one may pursue a rights-based analysis, focused on the non-consensual nature of the cutting and its targeting of the sexual anatomy (i.e., the "private parts") of a vulnerable person without urgent medical need (38). Either route leads to the conclusion that, insofar as the female-affecting procedures are morally condemnable, so too are the procedures affecting children with intersex traits.

In fact, the problem runs deeper. Some people with intersex traits may *also* be female, whether genetically, by sex assignment, or in terms of their gender identity (39–41). This makes it even harder to ground a principled distinction between medically unnecessary "female" and "intersex" genital cutting. As Nancy Ehrenreich and Mark Barr argued in a classic article exploring this comparison, if one extends the arguments usually raised against NWFGC to medically unnecessary intersex cutting, one will find that they have "equal force in the intersex context" (22) (p. 75). And yet the latter procedures remain legal and are largely accepted in virtually all of the same Western societies that have categorically forbidden NWFGC.

Can this situation be justified? Ehrenreich and Barr argue otherwise. They allege that a double standard is at play that reflects Western cultural bias and moral exceptionalism. According to them, "the posture of white privilege" that is encoded in prevailing arguments against NWFGC prevents Western opponents of such cutting from acknowledging that "similar unnecessary and harmful genital cutting occurs in their own backyards" (22) (p. 75). Ehrenreich and Barr conclude that this insight has policy implications: the unequivocal condemnation of those who practice NWFGC "is inappropriate unless we are equally willing to condemn physicians performing intersex operations" (22) (p. 75).

[2] Note: terminology surrounding sex categorization is controversial. Language used by and about members of marginalized populations is often contested (34) but people who are born with differences of sex development—or who have a range of what are sometimes called variations of sex characteristics or intersex variations—are identifiable precisely because their bodies raise questions about their membership in either the male or female sex class, according to conventional or biological criteria for sex class membership in their society (35). Decisions about such matters are often made by others according to their interests and not necessarily those of the affected individuals. People with intersex variations, medical professionals, parents, human rights advocates, and other stakeholders vie for terms and concepts that are consistent with their aims, leading to a proliferation of terms and no consensus about how to use them. This footnote is adapted from (36) and was drafted in consultation with Morgan Carpenter, the current president of Intersex Human Rights Australia.

116 **Table 1. Non-Western FGC vs. Western-style "Cosmetic" FGC.** Adapted from (42,43).
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Category	*Non-Western FGC or "Female Genital Mutilation"* as it is defined by the WHO: namely, all medically unnecessary procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs—widely condemned as human rights violations and thought to be primarily non-consensual	*Western-style "Cosmetic" FGC:* typically medically unnecessary procedures involving partial or total removal of the external female genitalia, or other alterations to the female genital organs for perceived cosmesis—widely practiced in Western countries and generally considered acceptable if performed with the informed consent of the individual.
Procedures: WHO typology	Type I: **Alterations of the clitoris or clitoral hood**, within which Type Ia is partial or total removal of the clitoral hood, and Type Ib is partial or total removal of the clitoral hood and the clitoral glans.	**Alterations of the clitoris or clitoral hood,** including clitoral reshaping, clitoral unhooding, and feminizing clitoroplasty
	Type II: **Alterations of the labia**, within which Type IIa is partial or total removal of the labia minora, Type IIb is partial or total removal of the labia minora and/or the clitoral glans, and Type IIc is the partial or total removal of the labia minora, labia majora, and clitoral glans.	**Alterations of the labia**, including trimming of the labia minora and/or majora, also known as "labiaplasty"
	Type III: **Alterations of the vaginal opening** (with or without cutting of the clitoris)**,** within which Type IIIa is the partial or total removal and appositioning of the labia minora, and Type IIIb is the partial or total removal and appositioning of the labia majora, both as ways of narrowing the vaginal opening.	**Alterations of the vaginal opening** (with or without cutting of the clitoris), typified by narrowing of the vaginal opening, variously known as "vaginal tightening," "vaginal rejuvenation," or "husband stitch"
	Type IV: **Miscellaneous,** including piercing, pricking, nicking, scraping, and cauterization.	**Miscellaneous**, including piercing, tattooing, pubic liposuction, and vulval fat injections
Examples of relatively high-prevalence countries	Depending on procedure: Burkina Faso, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Indonesia, Iraqi Kurdistan, Liberia, Malaysia, Mali, Mauritania, Senegal, Sierra Leone, Somalia, Sudan, and concomitant diaspora communities	Depending on the procedure: Brazil, Colombia, France, Germany, India, Japan, Mexico, Russia, South Korea, Spain, Turkey, United States
Actor	Traditional practitioner, midwife, nurse or paramedic, surgeon.	Surgeon, tattoo artist, body piercer.
Age at which typically performed	Depending on the procedure/community: typically around puberty, but ranging from infancy to adulthood.	Typically in adulthood, but increasingly on adolescent girls or even younger minors; intersex surgeries (e.g., clitoroplasty) more common in infancy, but ranging through adolescence and adulthood.
Presumed Western status	Unlawful and morally impermissible	Lawful and morally permissible
Analysis	Given that there is overlap (or a close anatomical parallel) between each form of WHO-defined "mutilation" and Western-style "cosmetic" FGC, neither of which is medically necessary, one must ask what the widely perceived *categorical* moral difference is between these two sets of procedures. Controlling for clinical context—which varies across the two sets and is often functionally similar—the most promising candidate for such a difference appears to be the **typical age**, and hence **presumed or likely consent-status**, of the subject. But if that is correct, it is not ultimately the degree of invasiveness (which ranges widely across both sets of practices), specific tissues affected, or the precise medical or nonmedical benefit-to-risk profile of medically unnecessary (female) genital cutting that is most central to determining its perceived moral acceptability. Rather, it is the extent to which the affected individual desires the genital cutting and is **capable of consenting** to it. This suggests that the core of the rights violation is the lack of consent regarding a medically unnecessary interference with one's sexual anatomy, a consideration that applies regardless of the sex or gender of the non-consenting person.	

What about (psychosocial) health benefits?

In opposition to the view presented in the previous section, it might be argued that there are in fact morally relevant differences between NWFGC and intersex genital cutting that can explain their differential treatment in Western law and policy. For example, it is sometimes claimed, albeit without strong or consistent evidence, that children with visibly atypical genitalia would be embarrassed or otherwise psychosocially disadvantaged by virtue of their bodily difference. If this were so, early surgery to "normalize" their genitals (i.e., before they are capable of providing their own informed consent) could potentially be justified on grounds of mental health—notwithstanding the risks to physical or indeed mental health entailed by the surgery itself (30,44). At the same time, following the WHO, it is often claimed that NWFGC "has no health benefits," and only causes harm (1). Taken together, these two claims might seem to ground a principled distinction between the two forms of genital cutting, helping to explain why the former is considered permissible in Western countries while the latter is not.

However, there are problems with this line of reasoning. First, as noted, there is very little good evidence to support the claim that non-consensual intersex "normalization" surgeries do in fact reliably tend to promote mental health (45). At the same time, there is growing evidence that many individuals who were subjected to medically unnecessary genital cutting when they were pre-autonomous regard themselves as seriously harmed by it, both physically and psychologically (46–48).

Second, even if there were strong evidence that non-consensual intersex genital cutting promoted mental health (for example, by reducing the chances of being teased for having genitals that are not visually typical for one's assigned sex), this would not make the surgeries "medically necessary" as defined in Box 1. This is because all other less harmful means of promoting mental health would first have to have been ruled out as infeasible or ineffective (e.g., encouraging more accepting attitudes toward genitals of all shapes and sizes, addressing teasing or bullying directly, encouraging resilience and self-acceptance through psychosocial means, such as therapy or counselling, or at least waiting until the person whose most intimate anatomy would be permanently affected could meaningfully participate in any decisions about surgery) (49).

Third, even if intersex genital cutting could be shown to promote mental health by mitigating purported social harms associated with being perceived as "different," this would not serve to categorically distinguish it from NWFGC. This is for the simple reason that, in societies where genital modification of children is culturally normative, any child who has not undergone the prescribed modification would be left with "atypical" genitalia vis-a-vis local standards. Because of this, the child would presumably be just as liable to teasing or other forms of social

disadvantage claimed to adversely affect a person's mental health (50–52). If that is right, then NWFGC may in fact have "health benefits" in certain contexts according to the WHO's own definition. According to the WHO, "health" is not simply the absence of disease or infirmity, but rather, is a state of "complete physical, mental, and social well-being" (53). Yet as the paediatrician and scholar Robert Van Howe has argued:

> Many women who were circumcised as children do not perceive themselves as harmed. When the many [alleged] cultural benefits are factored in, practitioners could easily convince themselves that any harm is more than offset by the many perceived benefits. (54) (p. 167)

Indeed, given such a broad definition of health as the one employed by the WHO, it is misleading to assume that the mere attribution of "health benefits" (of some kind or another) to non-consensual genital cutting is sufficient to make it morally permissible. This is especially the case if there are other, less risky, more autonomy-respecting ways of achieving the same or substantively similar health benefits (55). Such an assumption can only incentivize supporters of non-consensual genital cutting to medicalize the practice and look for evidence of "health benefits," however questionable or readily achievable by other means (see Box 2), as has happened historically in the case of male circumcision (56–58).

In the case of NWFGC, however, the WHO opposes medicalization even as a harm reduction measure, claiming instead that such procedures are *intrinsically* wrong (59). But if NWFGC is intrinsically wrong unless medically necessary, then the purported lack of health benefits is conceptually irrelevant to the moral analysis. In other words, even if there *were* health benefits to medically unnecessary, non-consensual female genital cutting, the WHO would still regard such cutting as a rights violation. The only conceivable exception to this rule would be if (a) the health benefits were central to the child's well-being and (b) they could not be achieved in a less harmful or disrespectful way (for example, a way that didn't involve non-consensual genital cutting) (60).

Box 2: Might NWFGC have *physical* health benefits?

The case of "infant labiaplasty." Adapted from (55).

> The WHO defines female genital mutilation or "FGM" as all medically unnecessary cutting of the external female genitalia, irrespective of consent. It also asserts that such cutting "has no health benefits, only harms." But it is not clear that this is so. Consider medically unnecessary cutting of the labia, a WHO Type II "mutilation." When carried out by a licensed medical practitioner in a Western country, such cutting may be termed "labiaplasty" and regarded as a form of genital enhancement. Labiaplasty is similar to penile circumcision, a practice the WHO approves on

> grounds of health benefit, in that it concerns genital tissue whose removal does not necessarily preclude sexual enjoyment, but which nevertheless has certain tactile and sensory properties that many people value. It is also similar to circumcision in that the genital tissue it removes is often moist and may trap bacteria, can become infected or even cancerous, may be injured or torn during sexual activity, and requires regular washing to maintain good hygiene. Removing the labia, therefore, likely does confer at least some potential health benefits in that it reduces the surface area of genital tissue that is not essential for sexual function (narrowly construed) but which still has the potential to occasionally pose a health problem of one kind or another. In addition, such removal may plausibly confer at least some "mental" health benefits for some women, insofar as they prefer the aesthetics of a vulva that has been subjected to labiaplasty and this helps them feel more comfortable in their bodies. Now, assume for the sake of argument that labiaplasty does in fact have the above-mentioned health benefits, and that performing labiaplasty in infancy is *medically* better (technically simpler, safer, more cost-effective, shorter healing time, etc.) than labiaplasty performed on a consenting adult. Would these considerations be enough, from a moral perspective, to make non-consensual "infant labiaplasty" acceptable? Would it be tolerated by the WHO? If not, it seems the "no health benefits" claim is a moral red herring, and that the more pertinent issue is whether or not the affected individual has given their informed consent.

In any case, insofar as anticipated health benefits are deemed to be morally relevant, the "mental and social well-being" allegedly afforded to children through ritualistic genital cutting in societies where such cutting is culturally normative[3] should be given no less moral weight (all else being equal) than the "mental and social well-being" allegedly afforded to children with intersex traits through "normalization" surgeries in Western countries. Yet in the case of NWFGC, it is widely argued that, instead of surgically shaping children's genitals to make them conform to unjust or harmfully constrictive societal expectations, it is the societal expectations themselves that should be changed (for example, through education and consciousness-raising). If surgically unmodified genitalia thereby became more culturally normative, a "lack of genital cutting" could no longer reasonably be construed as prejudicial to a child's mental health or social well-being (61).

Assuming that such cultural change is morally desirable on balance, it should, at least presumptively in societies that recognize a gender-inclusive right to bodily integrity (62), be pursued not only with respect to the genitals of non-consenting persons who have characteristically female sexual anatomy, but rather, with respect to all non-consenting persons regardless of their anatomy.

[3] For example: acceptance by one's peers and elders, avoidance of teasing, initiation into a religious community, elevation to adult status in the case of a rite of passage, greater perceived attractiveness, and so on (24).

The right to bodily, especially genital, integrity

The legal theorist Kai Möller has recently argued that the categorical condemnation of NWFGC—including its relatively minor forms such as medicalized nicking, pricking, or partial removal of the clitoral hood (the most common forms of ritual female genital cutting in Malaysia, for instance) (63)—cannot be adequately justified using current approaches. That is, it cannot be justified by adopting a "balancing" approach centered on the contestable weighing-up of expected harms and benefits (including "health" benefits, broadly construed). Instead, he argues that "*even if* a plausible claim could be made that the child would benefit from being genitally cut, it is wrong as a matter of principle to 'trade' a part of the child's genitals for another supposed benefit" (10) (p. 24, emphasis added). In other words, given the highly personal, psychosexual significance of the genitals to most people, such a controversial "trade" should be the prerogative of the affected individual to assess in light of their own values when they are sufficiently autonomous. According to this view, "the wrong of genital cutting flows not (in the first instance) from contingent empirical factors relating, for example, to harm or social structures, but from the child's right to have his or her physical integrity respected and protected" (10) (p. 24).

A similar conclusion was recently reached by a large international coalition of more than 90 scholars in law, medicine, ethics, and other areas. These authors noted that under most ordinary circumstances, cutting any person's genitals without their own informed consent is a gross violation of their right to bodily integrity and sexual self-authorship. Therefore, such cutting should be considered "morally impermissible unless the person is nonautonomous (incapable of consent) and the cutting is medically necessary" (42) (p. 17). Otherwise, the authors argued, the decision should be left to the affected individual, with social change efforts aimed at protecting "all non-consenting persons, regardless of sex or gender, from medically unnecessary genital cutting" (42) (p. 22). Such a policy would eliminate any double standards between medically unnecessary intersex genital cutting and NWFGC.

Conclusion

We would like to conclude by drawing some lessons from our analysis for nurses and other healthcare practitioners. Within the nursing literature, it is common to read about NWFGC from a child safeguarding perspective. In line with this perspective, the cutting, regardless of severity or parental intentions, is usually characterized as harmful and demeaning, or even as a form of "child abuse." Although it is the case that families who practice what they call "female circumcision" virtually always also practice male circumcision (but not vice versa) (17,64,65), only the former type of cutting is described as abusive. Accordingly, such language helps to establish a seemingly uncrossable conceptual boundary: between what "they" do to children's genitals in far-off countries (deemed to be categorically impermissible) versus what "we" do to

children's genitals in the more familiar context of Western medicine (deemed to be a matter of parental choice).[4]

So, for example, it is often stressed that NWFGC is practiced by "minority ethnic communities" (68); that is, persons who are likely to be perceived as cultural outsiders—the proverbial "Other." Consequently, nurses and other healthcare providers who receive training on this topic are typically advised to "educate" ethnic minority parents who are even suspected of supporting NWFGC,[5] instructing them only about drawbacks of the practice. For example, the Registered Nurse Misbah Shah recently argued:

> healthcare professionals such as nurses play an essential role in educating patients and informing them of the negative effects the operation could potentially cause … nurses can identify females who are at risk for genital mutilation. For instance, one factor to consider is that the daughters of women who have had their genitalia harmed are in jeopardy. Since their mothers experienced the painful act, there is a chance that the tradition will continue in the family. Therefore, nurses must provide patient education and be aware of individuals who may be at risk. (72)

Notice the language here: "at risk," "mutilation," "harm," "jeopardy," "tradition." Now imagine using such language to refer to medically unnecessary intersex genital cutting or even routine penile circumcision, both of which are commonly performed on non-consenting minors by Western medical professionals for largely cultural reasons at the behest of parents. We have argued that if an argument centered on "health benefits" cannot be used as moral justification for NWFGC, it cannot justify these practices either. So why aren't nurses and other healthcare providers trained to convince parents who are considering these "Western" practices not to pursue them?

The question answers itself. It must be very hard for a nurse or other healthcare provider to imagine "educating" a parent about the "risk of genital mutilation" to which their child may be exposed, when their own professional organizations openly tolerate at least some such "mutilation" (see footnote 4) and their own colleagues willingly perform it for a fee (73). Perhaps, then, it is "we" in the West who need to be educated about the questionable ethics of our own genital cutting "traditions" (notwithstanding that those traditions have been medicalized in recent history) (56,74–76). And perhaps it is "we" who need to be educated about the deep-seated cultural bias that prevents us from holding ourselves to the same moral standards that we so confidently apply to others (77–80).

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[4] For example, both the American College of Nurse-Midwives (ACNM) and the American Society for Pain Management Nursing (ASPMN) regard medically unnecessary penile circumcision to be ethically acceptable and not to violate the child's right to bodily integrity. For example, the ACNM states that the "decision to circumcise is challenging in that the procedure permanently alters the anatomically intact male penis" but nevertheless counsels that midwives "may provide newborn male circumcision as part of expanded scope of practice" (66) (p. 2). Meanwhile, the ASPMN states: "Parents determine what is in the best interest of their child; they may … choose [medically unnecessary] circumcision for their male infant because of cultural, religious, or ethnic traditions" (67) (p. 379).

[5] In practice, this may amount to little more than racial profiling (69–71).

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