This paper explores the ethical implications of female genital mutilation. It argues that irrespective of cultural reasons underlying the practice, it is ethically indefensible. It suggests that the medical profession has a particular obligation in this regard neither to participate in nor to facilitate the practice, and to take a public stand opposing it. The fact that some women may agree to their own genital mutilation does not change this. Such agreement is ethically invalid because it either lacks voluntariness or is based on an inadequate understanding of the true nature of the situation.

INTRODUCTION

FEMALE CIRCUMCISION' is a phrase that loosely refers to three related but distinct practices: clitoridectomy or clitoral excision, female circumcision, and infibulation or Pharaonic circumcision. The first, as the term suggests, is the removal of the clitoris (Shandaal, 1967), the second usually involves clitoridectomy and excision of the labia minora (Toubia, 1993), whereas the third involves removal of the labia majora and minora and the mons veneris and often the clitoris as well, and subsequent suturing of the remnants of the labia majora (Hicks, 1993).

In recent times, the procedures have also come to be referred to compendiously as 'female genital mutilation'.

The procedures have traditionally been performed by lay practitioners. Not surprisingly, they present serious health hazards when they are preformed in the community setting and without proper operating conditions. Haemorrhaging, postoperative shock, and infections can be numbered as immediate post-operative complications. In recent times, therefore, some health care professionals have become involved in performing the procedures so as to minimise the health risks.

However, whether performed by lay practitioners or health care professionals, and whether practised under conditions of exemplary hygiene and with superb professional skill or under unhygienic conditions and with no surgical expertise, the sequelae of female circumcision (particularly of infibulation) are severe. There are diagnosable psychiatric effects on those who have undergone the procedures (Baasher, 1979); personal hygiene becomes problematic; chronic infections of the uterus and vagina are common; child-birth without defibulation presents a potentially life-threatening situation (Dewhurst and Michelson, 1964); and keloid scar formation can be so severe as to interfere with walking (Toubia, 1994). That is why the WHO has coined the phrase 'female genital mutilation'.

PREVALENCE

Female genital mutilation is essentially unknown in most of the world; however, it is relatively common in Islamic north-eastern Africa and is practised to some degree in Indonesia and Malaysia. Its greatest incidence is in the Sudan, Egypt, Ethiopia, Kenya, Somalia, Nigeria, Mali, Upper Volta, and Senegal, where estimates of its prevalence range from 10 per cent in Zaire to 90 per cent in Sierra Leone, Ethiopia and Eritrea and go as high as 98 per cent in Somalia (Hosken, 1981).
Historically, the practice antedates the advent of Islam, finding its roots in ancient Egypt and Arabia (Hansen, 1972). Arguably, therefore, it constitutes an integral part of the social and cultural heritage of the societies that originate in this area—a situation that is reflected by the fact that members of these communities carry the practice with them when they emigrate to other parts of the world. Current estimates of its world-wide incidence range from 74 million to 114 million women.

At least partly because of this recent global dispersion, the procedures have become a matter of intense scrutiny and critique, since they are fundamentally at variance with what is considered acceptable in the societies to which the various peoples emigrate or where they seek asylum. In almost all cases, the procedures have been condemned as indefensible and barbaric mutilation of women. In that context, they have even been portrayed as graphic expressions of man's inhumanity to woman.

However, criticism has not been limited to voices that find their basis in different cultural perspectives. More recently, the procedures—especially infibulation—have been criminalised even in some of the countries in which historically they have been practised. However, it appears that this prohibition has not resulted in any criminal procedures and the practice itself continues unabated.

The situation is especially difficult for physicians in non-African countries who are approached by members of these cultural diasporas to perform the procedures. Physicians who accede to such requests reduce the danger of the medical complications that attend the practice when performed by lay persons at the community level. However, in so doing, they not only become party to the perpetuation of a practice that is inherently unethical, but also become direct agents of harm that has no medical justification. On the other hand, while physicians who refuse to accede to such requests avoid the latter consequences, they run the risk of driving the practice back to the community level and thus becoming indirect agents of precisely the harm just mentioned.

Therefore the central question for the medical profession in this connection is whether the goal of minimising harm outweighs the cost presented by unethical treatment.

To resolve this issue, it may be useful to look at the reasons that are given for the continued practice of female genital mutilation.

DEFENCE OF THE PRACTICE

Several reasons are given for the continuation of the practice. They include the claim that it is necessary to retain cultural identity, that it is religiously required (grounded in Islam), that it is a rite of passage which inducts women into an adult female role in those societies; that it is necessary to ensure female modesty, chastity and fidelity; that it is required for the sake of female morality by curbing female sexual 'deviance' and that it ensures male control over women, decreases women's sexual interests; etc. It has even been lauded as leading to a reduced reproduction rate.

In one way or another, these defences are culture-bound. However, in recent times the practice has also been defended from a more general sociological perspective. The defence is part of a general position
which argues that practices which are grounded in the cultural beliefs of a particular society are not a fitting subject of analysis and critique by anyone outside of that cultural setting. Each society and each culture has its own standards and values, and the very fact that a particular practice is part of the cultural heritage of a people marks it as integral to the value-system of that people. No one set of these values is more valid than another. In fact--so the reasoning goes--to criticise a culture-bound practice from the outside is to engage in what amounts to cultural and moral imperialism. Finally, it has been argued that criticism of the practice has nothing to do with ethics but everything to do with politics. It is merely another example of strident feminist critique which sees male oppression of women and male desire for domination behind every woman-centred cultural practice.

These perspectives are well illustrated by one recent commentator (Hicks, 1993), who claims that . . . such practices [as clitoridectomy, female circumcision and infibulation] have all too often been exploited in the media as portraying a specific, albeit symbolic example of man's inhumanity to women. . . . But is this in fact the case? Or is infibulation but one of a myriad of cultural traits developed, over time, by individual social systems to define and circumscribe the social role of those members most pivotal to its structural survival? . . . Perhaps of equal relevance is the question of what the (small) war waged by feminists and the various international interest groups against all forms of female circumcision tell us about our own cultural biases and insecurities. Would we not be better served by first determining the importance and embeddedness of this practice in the social systems in which it occurs?

When presented in this way, criticism of female circumcision and associated practices is immediately stamped as the strident attack of a valuation-ally biased group against a value-system that is simply different.

ETHICAL PRINCIPLES AND CULTURAL VALUES

It can be argued that these objections are ethically unfounded and that its historical roots and cultural connections notwithstanding, female circumcision and associated practices are ethically indefensible and that physician participation in them constitutes a fundamental violation of medical ethics. That is to say, in general terms, the fact that a particular culture engages in a specific activity does not by itself sanction the activity as ethically defensible; nor is a particular practice ethically acceptable simply because is rooted in the history of that culture or finds justification in the religion of that people.

Ethics is not a matter of what people in fact are doing or what they believe. It is a matter of what they ought to do. The reason is that ethics is based not on personal or cultural beliefs but on principles that find their basis in what it is to be a human person. Because they are thus rooted in the nature of human beings as persons, they hold for all human beings irrespective of cultural, religious or national setting. Therefore sociological and historical considerations that focus on belief systems and cultural values simply do not address the question whether a particular practice is ethically defensible. That question can only be settled by asking whether the practice is defensible in light of these fundamental ethical principles.

There are such principles, and they are internationally recognised as such. They underlie the Universal Declaration of Human Rights, and form the basis of many international agreements, treaties and actions. Their impact can be seen in the legal retribution against Nazi Germany and Japan after the Second World
War. Condemnation of the medical experiments conducted by Japan and by Nazi Germany was not grounded in cultural imperialism. It was based on recognition of these fundamental ethical principles and acceptance of the fact that they apply to all people irrespective of cultural and social setting simply because they are human beings. A similar message is conveyed by current international sanctions against peoples and countries for crimes against humanity involving torture and civil rights violations. A further example is provided by the fact that slavery has universally been outlawed as being incompatible with the inherent dignity of the human person. The relevance of these considerations for culture-bound practices is patent.

Societies are not mere aggregates of living bodies. They are functionally interrelated social units constituted of human persons. Therefore even those practices that are rooted in the cultural history of a people, and that find their basis in the fundamental values that structure that people's view of life, are not immune from ethical critique. Such critique is legitimate and appropriate because it is grounded in universally valid principles that originate in what it is to be a human person. Cultural practices, therefore, are acceptable only when they are in accordance with these principles, and cultural values should be honoured only if they are ethically defensible. Accordingly, any culture that condones, any family that demands, and any person who engages in practices that violate these fundamental principles is ethically reprehensible.

Female circumcision in its various forms falls subject to this critique. More specifically, female circumcision has no medical justification. It has purely historical roots and is based on culturally entrenched values. However, the values that license it are predicated on a profound disrespect for the dignity of women as human beings, and their acceptance requires the thesis that women somehow have a lower ethical status because of their gender. Therefore these values involve a violation of the principles of autonomy and respect for persons and of equality and justice.

THE ROLE OF PHYSICIANS

These considerations have immediate implications for the medical profession and for health care agencies. They entail that physicians who participate in the practice--and there are such--no matter what their intention, are guilty of a violation of medical ethics. This can be argued in two ways: by reference to national and international codes of medical ethics; and independently of such codes, by reference to the nature of medicine as a profession. That is to say, the World Medical Association accepts the fundamental ethical principles that were identified above. They are expressed in various ways in the Code of Ethics of the World Medical Association and underlie its various ethical pronouncements and declarations. It follows that in the eyes of the World Medical Association, medical practice should be in accordance with these principles, and that failure to uphold them constitutes a violation of the ethics of the profession irrespective of historical or cultural position.

More specifically, the International Code of Medical Ethics, as adopted by the Assembly of World Medical Associations in 1949 and amended in 1983, states that 'A physician shall, in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity'. The Declaration of Geneva states that 'the health of my patients will be my first consideration'; that 'I will not permit considerations of religion, nationality, race,
party politics or social standing to intervene between my duty and my patient'; and that 'I will maintain
the utmost respect for human life from its beginning even under threat and will not use medical
knowledge contrary to the laws of humanity'. Further, the Declaration of Tokyo states that 'the doctor
shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or
degrading procedures . . . whatever the victim's beliefs or motives'.

Clitoridectomy, female circumcision and infibulation have no medical justification. Their sole reasons for
being practised are cultural (and possibly religious) in nature, based on values which may be historically
derived but which nevertheless deny the inherent and equal dignity of all persons. Furthermore, these
practices bear all the hallmarks of what the Declaration of Tokyo characterises as 'cruel, inhuman or
degrading procedures'. Therefore the World Medical Association, through the Declaration of Geneva and
the Declaration of Tokyo, is committed to the position that physicians who participate in female
circumcision, clitoridectomy or infibulation in whatever capacity, are practising in violation of the ethical
standards of the medical profession.

The ethical position thus enunciated by the World Medical Association clearly indicates that national
medical associations who do not take an active stand against these practices are ethically guilty by that
very failure. It is a fundamental ethical maxim that someone who is in a position to prevent an unethical
event from occurring, who can prevent that event without undue harm to her or himself, and who
nevertheless refuses to intervene thereby, through this inaction, becomes co-responsible for the outcome
itself. From this it follows that any national medical association which does not take appropriate and
active steps to halt these practices is also failing in its ethical obligations to the patients and to the society
which it purportedly serves.

This conclusion is entirely in accord with the recommendation of the British Medical Association
regarding torture: 'If the possibility of abuses of human rights comes to the attention of a medical
practitioner they [sic] have an ethical duty to take immediate action. . . . Doctors have a particular duty to
act when it is within their power, either individually or through their professional bodies to exert a
positive influence.' It is also in agreement with the Vienna Declaration of the World Conference on
Human Rights.

THE ETHICS OF MEDICINE ITSELF

Female circumcision, in its various forms, does not contribute to the health of female patients. Quite the
opposite: it predictably impairs the health status of the women who undergo the procedure. Consequently
female circumcision in its various forms stands in direct opposition to the nature of medicine as a health
care profession. It follows that a physician who performs the procedure violates the nature of the
profession.

The preceding argument is based on the nature of medicine as a health care profession. The fact that
medicine is a profession adds a further consideration. One of the characteristic of professions as
professions is that their practitioners stand in a fiduciary relationship to their clients (Bayles, 1989). The
nature of a fiduciary relationship expresses itself differently in different contexts, depending on the nature
of the profession itself. Therefore it expresses itself differently in law as opposed to, say, accounting,
architecture or medicine. However, all professions share this feature: the relationship which holds between the professional and the client is one of trust. Clients have the right to expect that professionals will do their best to advance the clients' legitimate rights and interests and that when the professionals are unable to do so, for whatever reason, they will advise them that this is the case.

In the case of medicine, this means that physicians are duty-bound, as a matter of trust, to do their best to advance the health status of their patients. This obligation holds as a matter of trust, and obtains whether the patient is competent or not, and irrespective of whether the patient is aware of the existence of this obligation. Therefore if a patient demands a particular type of treatment which would lead to a deterioration of the health status of the patient, the physician is duty-bound, as a matter of trust, to refuse this request.

It might be argued that physician participation in female circumcision is nevertheless justified because it minimises the damage otherwise done by these practices. However, this in effect amounts to physician participation in the continuation of the practice itself because it facilitates the practice. The situation here may be usefully compared with the predicament faced by physicians in countries that allow judicial torture. As the British Medical Association stated in that connection, 'It is wrong for a doctor voluntarily to participate in maltreatment even in the expectation of diminishing the damage to individuals'.

This is not to say that physicians should not do their utmost to try to repair the damage done by these practices once they occur. However, that is an entirely different matter. Furthermore, it also means that physicians may not, ethically, practice re-infibulation after child-birth, as happens in some countries.

**VOLUNTARY FEMALE CIRCUMCISION**

The literature contains anecdotal evidence that some of the women who are subjected to these procedures undergo them voluntarily. This appears to be especially true in the case of re-infibulation. Therefore it is at least theoretically possible to argue that these procedures are not unethical in all cases: that they are unethical only when they are performed involuntarily, whereas they are perfectly ethical when they are done on a voluntary basis.

This objection enjoys some superficial validity. However, all else aside, it would hold only in those cases where women voluntarily, competently and informedly request the intervention for reasons that are not themselves unethical. This would immediately exclude children.

Children are incapable of giving a competent consent that is appropriately informed and free. Especially in the contexts in which the choice between undergoing and not undergoing the procedure would be presented. Therefore even if the premise of the argument were to be granted, female circumcision, clitoridectomy and infibulation of children would still remain unethical.

In fact, the point can be pressed further. Female circumcision is usually performed on young girls before they have reached puberty. Such girls are minors, and therefore are in the care of their parents or of persons who act in statu parentis. Anyone who functions in such a capacity has the duty to discharge this role in the best interests of the child. Mutilation in the name of social custom is not in the best interest of children. Therefore parents (or those who take the place of
parents) violate the ethics of trust when they give proxy consent for such procedures.

This reasoning does not apply to adult women. Adult women sometimes request re-infibulation; and in their case--so the argument goes--the request should be honoured because it is competent, informed and voluntary. However, it is arguable that the adult women who request such procedures do not in fact make this request voluntarily and on the basis of a competent, uncoerced and informed consent. They make the request in order to meet the often unspoken but any case clearly understood cultural position that unless they undergo re-infibulation they will not be accepted within the immediate family unit or in society as a whole.

Therefore their request for the procedure is the result of a more or less overt and culture-based pressure that amounts to coercion: coercion which finds its basis in the general human need for social approval, family contact, and harmonious existence and membership in the family setting. Therefore what might be touted as competent and informed consent in fact is neither.

It may also be argued that women who even consider re-infibulation are conditioned by their social and cultural embedding into a cultural perspective which makes such an intervention seem reasonable and desirable. Therefore quite independently of any external pressure, such women are subjectively conditioned as a result of this acculturation and because of their embedding. Hence they are incapable of making a truly informed and competent choice in this regard, the appearances of freedom and their own protestations notwithstanding. Their choice may seem free, competent and informed. In fact, however, it is the result of a compromised will. Their will is overborne in much the same way that a child's will tends to be overborne by the values of the family unit in which the child is embedded and to which it wants to belong.

Clearly, these very considerations also undercut any argument based on the claim that women have a right to control their bodies. The claim to right of control is of course correct. However, the exercise of such control is always predicated on competence and informed consent. Since that is not present in this kind of situation, the reasoning fails.

Finally, even if the reasoning centring around considerations of autonomy and choice were valid, it nevertheless is incapable of establishing the desired conclusion. The fact is that this reasoning is predicated on the assumption that there is nothing inherently unethical about medical involvement in any practice as long as that involvement is based on competent and voluntary consent. However, as has already been shown, this assumption is incorrect. The very nature of medicine as a health care profession forbids physicians from performing certain interventions as ethically unacceptable--female circumcision being among them.

MIDWIVES AND OTHER LAY HEALTH CARE PROVIDERS

With due alteration of detail, the preceding considerations also apply to lay midwives and native healers in the jurisdictions in which these practices are at home. To be sure, the conduct of these persons is not governed by the rules and regulations of the medical profession.
However, it should be recalled that the ethical force of the Declarations and Codes of the WMA does not derive from the fact that its various member Associations have agreed to abide by them. That agreement is merely a public recognition of the binding force of the fundamental ethical principles that apply to all people, irrespective of their social position or professional affiliation. They apply to all human persons because they are persons. Therefore they apply to midwives and other lay practitioners as much as to physicians and nurses. They even apply to the older village women who also engage in the practice. The difference between them and physicians is that since physicians have greater education and an elevated position of trust, they have a greater degree of responsibility in such matters. However, this does not change the fact that in all cases, no matter who performs these procedures, the practice is ethically indefensible.

CONCLUSION

It is fashionable to argue that practices which are grounded in the cultural beliefs of a particular society are not a fitting subject of analysis and critique by persons who are outside of that cultural setting; that each society and each culture has its own standards and values and that no one set of these is more valid than another; and finally, that to criticise a culture-bound practice from the outside is to engage in mortal imperialism.

However, this argument is fallacious. There are fundamental ethical principles which hold for all persons simply because they are persons. Therefore cultural practices are acceptable only when they are in accordance with these principles, and cultural values should be honoured only if they are ethically defensible. Clitoridectomy, female circumcision and infibulation have no medical justification. They are mere genital mutilation. As such, they violate the principle of autonomy and respect for persons. Accordingly, any culture that condones, any family that demands, and any person who engages in them, is ethically reprehensible. The fact that some women may agree to their own genital mutilation does not change this, since such agreement lacks informed, competent and voluntary consent.

Medical association have an ethical obligation, rooted in the ethics of the profession itself, to do all they can to outlaw the practice and individual health care professionals have an ethical obligation to do their personal best to stop it. Governments and governmental agencies have a duty to stamp out the practice as an affront to the dignity of the human person.

REFERENCES


By E. W. Kluge
Department of Philosophy, University of Victoria, British Columbia, Canada
Correspondence should be addressed to: E. W. Kluge, Department of Philosophy, University of Victoria, British Columbia, Canada.