



Medicine, Morals, and Female Genital Cutting

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The arrest of Jumana Nagarwala and her colleagues, in what has become the first case to be tried under the federal law prohibiting female genital mutilation, has brought female genital cutting practices into public conversation once again. Dr. Nagarwala, an emergency medicine physician from a small Shia sect known as the Dawoodi Bohra, was [imprisoned in April \(https://www.clickondetroit.com/news/dr-jumana-nagarwala-to-be-released-on-45-million-bond-while-awaiting-fgm-trial\)](https://www.clickondetroit.com/news/dr-jumana-nagarwala-to-be-released-on-45-million-bond-while-awaiting-fgm-trial) for performing a religious ritual called khatna in an outpatient clinic in Detroit. This ritual involves the nicking of the prepuce, or clitoral hood, and is, for this community, grounded within Islamic scriptures and aimed at gender equity; young males are circumcised and females are nicked.

All forms of female genital cutting evoke passionate arguments both in the public square and in the academy. Over the past 30 years, there have been many international and local campaigns seeking to eradicate the practice. These efforts have met with limited success and some cultural groups have decried the trampling of their traditions. Notably, the Public Policy Advisory Network on Female Genital Surgeries in Africa [reports \(http://indigenousspsych.org/Discussion/forum/PDF/2012%20-%20seven%20things%20to%20know%20Hastings%20Center%20Report.pdf\)](http://indigenousspsych.org/Discussion/forum/PDF/2012%20-%20seven%20things%20to%20know%20Hastings%20Center%20Report.pdf) that local residents may view genital surgeries as “aesthetic enhancements,” not mutilations.

Some bioethicists support harm-reduction strategies in which a minor type of female genital cutting is used in medical practice to ensure safety and prevent use of more severe forms of the procedure. Examples include the 1996 Harborview hospital compromise (<https://scholarship.law.duke.edu/cgi/viewcontent.cgi?referer=https://www.google.co.uk/&httpsredir=1&article=1024&context=dli>) and the 2010 policy statement (<http://pediatrics.aappublications.org/content/125/5/1088>) of the American Academy for Pediatrics.

In both instances allowing a “ritual nick” was argued to have no physical harms, to engender trust with minority communities, and to prevent more harmful procedures from taking place. The AAP clarified that it considered a nick to be less invasive than male circumcision. These proposals were met with vociferous objections and generated so much controversy that both parties eventually walked back their statements.

On the other side are bioethicists and women’s health advocates who argue that female genital cutting is an example of cultural violence perpetrated against women, disrespects autonomy over one’s body, and violates human rights (<http://onlinelibrary.wiley.com/doi/10.1111/j.1548-1433.2008.00028.x/full>). They propose a zero-tolerance strategy prohibiting all forms of the practice, including the nick. Allowing any type of it within the scope of medicine is thought to add undeserved legitimacy to them. This strategy has been adopted by leading international public health institutions, such as the WHO and the United Nations.

There is a dire need for a reasoned dialogue and open debate over female genital cutting and the ethical responsibilities of physicians. As a society, we need to understand the issues at stake, carefully weigh the harms to individuals and communities, and then use law and policy to regulate the boundaries of this practice.

Informed discussion can only take place when we use language that does not marginalize and pre-judge, that opens dialogue rather than obstructs it. Thus, like others (<https://www.sun.ac.za/english/faculty/healthsciences/cmef/Documents/Female%20genital%20alteration.r>) before us, we believe that the term female genital mutilation, or FGM, should be discarded in favor of more neutral terminology. No doctor willfully seeks to mutilate. As we ask others to reexamine their rituals, we should reevaluate our use of language. For the terminology we use might reveal our unconscious biases, and a neutral stance is needed to allow the voices of those who engage in the practice to be heard.

Next, we require an accurate understanding of the procedures and data about their harms. To have a productive conversation about harm-reduction we need to understand all of the harms involved, both when the procedure is performed and when it is not. Thus, the medical data on harms and complications post-FGC; information about the social and psychological harms that accrue when these procedures take place and, importantly, when they are not performed; and anthropological data about the significance of these procedures in their cultural contexts all need to be brought to the dialogue. We need to objectively and critically examine both what we do and do not know before making moral assessments and delineating a path forward.

In sum, we call for a reasoned public dialogue about how best to eradicate harmful forms of female genital cutting through education, policies, and laws. We also encourage debate in the bioethics academy about how doctors can fulfill their ethical responsibilities while acknowledging the religious traditions of their patients.

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