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Article (Accepted Version)

Shahvisi, Arianne (2017) Why UK doctors should be troubled by female genital mutilation legislation. *Clinical Ethics*, 12 (2). pp. 102-108. ISSN 1477-7509

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Why UK doctors should be troubled by Female Genital Mutilation legislation

Arianne Shahvisi

Abstract

A UK doctor was recently acquitted of charges of reinstating a variety of female genital mutilation after delivering a child. In this paper I contend that this incident reflects a broader confusion concerning the ethico-legal status of non-therapeutic genital surgeries for children and adults, which are not derivable from tenets of medical ethics, but rather violate them. I argue that medical professionals have an obligation to announce and address this confusion in order to motivate legislative reform, since the inconsistency of the current law entrenches the underlying sexism and ethnocentrism upon which its sense depends. Without convincing arguments for (a) condoning treating male circumcision and female cosmetic genital surgery, and for (b) treating adult women-of-colour as lacking the capacity to consent, the current legislation stands in need of urgent revision.

Introduction

In early 2015, a junior registrar obstetrician stood trial in the UK facing charges of performing or encouraging female genital mutilation (FGM) in the case of *R v Dharmasena*, [1][2]. The obstetrician had delivered a child and then repaired the mother's external genitalia such that they closely resembled their appearance prior to childbirth; the mother is believed to have undergone labial infibulation at the age of six in her native Somalia, so the repair involved re-infibulation. Following the infibulation, a concerned midwife informed the obstetrician of its illegality. A senior consultant acknowledged the wrongdoing, but decided it would cause additional pain and humiliation to remove the stitches retrospectively, so the infibulation remained. The obstetrician has since been acquitted, and it has been revealed that the presumed "victim" did not request for charges to be pressed. This incident raises serious questions about the efficacy and paternalism of the structures that are supposed to safeguard against this oppressive practice.

In this paper I argue that current legislation regarding FGM is difficult to parse from a

medical ethics perspective. Either by ignorance or design, its supposedly good intentions are ultimately marred with sexism and racism, since the legislation devalues the consent capacities of racialized adult women, whilst the lack of legislation around male circumcision amounts to a failure to protect the bodies of male children. These legislative facts are hard to reconcile with medical professionals' *prima facie* understandings of adult capacity, child protection, and equity. As a result, not only should we be unsurprised when clinicians' actions indicate confusion, but we ought perhaps to expect clinicians to be confused, and might even learn something valuable from that confusion. The above obstetrician's actions may well reflect the inconsistency of the legislation surrounding non-therapeutic genital surgery, and the ambiguity regarding the target group for protection. In what follows, I describe the faults and shortcomings of the current legislation by drawing attention to the gap between its ostensive objectives and its problematic implications.

FGM and its discontents

FGM, also described as female circumcision, female genital alteration, or “cutting,” is an umbrella term for a diverse range of procedures involving the non-therapeutic modification or removal of parts of the female external genitalia with the intention of adhering to religious or cultural norms. The UK is one of twelve industrialised countries [3] to have introduced specific legislation to combat the practice, while many other countries (e.g. France, Germany, Canada, and the USA) rely on existing child protection legislation, and thereby confine concerns to minors.

In England and Wales, the Female Genital Mutilation Act 2003 [4] (hereafter: “the Act”) deems it an offense (incurring a maximum prison sentence of 14 years) ‘for a person to excise, infibulate, or otherwise mutilate any part of a girl’s labia minora, majora or clitoris.’ While the Act seems uncontroversial to the extent that it dovetails with child protection legislation and thereby enshrines the importance of consent and bodily autonomy—central tenets of medical ethics—it oversteps this mandate in its extension to *women*.

Definition 6 (1) of the Act rather jarringly states that “Girl includes woman.” That is to say, the terms of the Act apply to women exactly as they do to children. In other words, either the law does not derive its mandate from issues regarding child abuse, since adults and children have different consent capabilities (and therefore abuse vulnerabilities), or women, in this context at least, are deemed unable to give consent. If the first is true and child protection is not the central issue in FGM, another mandate for the legislation must be given. If the second is true, the law infantilises women. I take it that both are the case, and these constitute my first concern.

A second concern stems from the fact that there is no clear medical distinction to be drawn between (a) FGM, (b) male circumcision, and (c) female genital cosmetic surgery (FGCS), which commonly includes labial reduction, clitoral hood reduction, and clitoridectomy [3]. All three of (a) to (c) are non-therapeutic, incur some risk (critically dependent on the conditions under which the procedure is implemented, which is in turn a function of legal status), and derive from strongly policed socio-cultural norms.

Yet their treatment under UK law, and the responses they provoke in the public at large, are markedly different. From the perspective of medical ethics, all three seem deeply problematic in the case of children, and equivalently complex (but not obviously inadmissible) for adults consenting to such procedures occurring at their own expense. No convincing arguments exist to suggest enough of a difference to warrant a lack of legislation for the second two, compared with heavy-handed legislation for the first. I will therefore speculate that the difference can only derive from the different political contexts of the three, deriving from their presumed associations with particular groups. The first is largely associated with Muslims and Africans, the second is known to be essential within Judaism,¹ and the third is associated with wealthy women.

Male circumcision, through its primary association with Judaism, within which it is a prerequisite, evades criticism through rightful sensitivities regarding anti-Semitism in

1 There is a false dichotomy at work which assumes that FGM is associated mainly or exclusively with Islam and male circumcision is associated exclusively with Judaism. In fact, FGM is associated with Islam and Christianity (amongst other cultures), while male circumcision is associated with Christians, Jews, and Muslims (amongst other cultures).

post-Holocaust Europe. Here I will not explore this association further, but merely observe the incongruity of collective atonement for major political evils resulting in the denial of bodily autonomy and *ipso facto* religious self-determination to infants. Merkel and Putzke [5] analyse the analogous lack of legislation in Germany as:

decisive for German politics for an obvious reason, namely for its link with the darkest part of German history: the genocidal mass murder of Jews in the Nazi era. [...] [W]e are convinced that the sheer act of circumcising an infant would not be tolerable, and would hardly be tolerated, under German law, were it not for this peculiar religious background that refers to grave historical guilt (p. 448).

I note this in order to suggest the cognate role that political context may be playing in legislation around FGM, which is fallaciously but widely associated with Islam at a time at which the UK public discourse is rife with both Islamophobia and with security fears associated with extreme Islamic ideologies.

Male circumcision (note: rarely “male genital mutilation”²) is a close parallel to FGM in all but one sense. Both are performed on the healthy, protective, erogenous tissue of children who cannot consent. Neither has any proven health benefit, while both have some associated risk, and carry implications for later sexual potential. Yet while male circumcision is usually viewed as an isolated act of faith, FGM is, at least in part, intended to curtail and/or control a woman's sexuality.³ In other words, FGM is constructed by, and serves, a patriarchal agenda. In this sense, it rightly meets with specific critique from feminists, as yet another way of objectifying women and reducing their agency.

But this is not the primary angle along which it is criticised, and if it were, FCGS would be just as liable to reproof,⁴ since its primary motivation is presumably to make external genitals closely resemble another set of harmful and objectifying norms: those of the global pornography industry [11]. Further, it is not at all clear that male circumcision does

² Darby and Svoboda [6] and Arora and Jacobs [7] address the issue of language.

³ It is less often acknowledged that male circumcision has implications for penetrative sex and masturbation, thereby curtailing the sexuality of boys and men [8]. And, as Hellsten [9] notes, in traditional Judaism “male circumcision is a means to moderate the sexual pleasure of men and their attraction to women” (p.252).

⁴ This argument is also made by Dustin [10].

not work in the service of another face of the same patriarchy. Fox and Thomson [12] note that the legality of this painful marker of the passage to masculinity highlights the way in which male bodies tend to be constructed by law as “invulnerable to harm” (p. 465). This “masculinity/pain nexus” is entrenched by the way in which “circumcision is privileged as an early moment that associates masculinity with endurance and pain” (p. 466). Perhaps this dangerous view of boys and men as immune to hurt or abuse, deriving from broader patriarchal ideas of male supremacy, partially explains the difference in legal status between non-consensual mutilation of boys' and girls' genitals.

Let the situation be put in plain terms. “Cultural” or “ritual” non-therapeutic genital surgery is illegal even for *adult* women, but perfectly legal even for male *children*. Further, “merely” cosmetic non-therapeutic genital surgery is legal for *all* adults. (Though non-white adult women beware: you will be refused if there is a whiff of “ritual” about your choice.) If doctors are not confused as to where this leaves them as practical ethicists, they are not thinking hard enough.

Gender, race, and autonomy

It is trivial to state that the primary ethical critique of FGM should focus on the rights of the child. The secondary ethical critique of FGM is a feminist one. In a medical setting, a shared value of feminism and medical ethics—that of protecting bodily autonomy—comes to the fore. To return to the case study that opened the paper: if the doctor clearly acted against the consent of the capacitated woman, either by making his own decision regarding the re-infibulation, or by preferentially carrying out the wishes of the other man present, there is a clear consent issue. If the doctor did not do his utmost to ensure that the woman was able to privately express her own preferences regarding her own body, then sufficiently autonomous informed consent was not secured.

On the other hand, if he carried out the wishes of the woman to have *her* external genitalia as *she knew them* reconstructed, then I do not see that any wrongdoing has occurred. In the absence of current legislation, it seems difficult to make the case that *all* doctors (and all people besides) should be forbidden from reinstating the original stitches, especially if

vaginal/perineal sutures are already required to return the genitals to “normal.” To refuse to do so might be seen to amount to the doctor asserting his view that her external genitalia prior to childbirth were not “right” in some sense, and making his own “correction.”

A person's external genitalia are an integral part of her identity. We learn to use our reproductive organs as we begin to develop our sexual identities, and they form a significant part of our intimate relationships with ourselves and others. It is precisely because of this unique role—both as pleasure centres and through their associations with trust and intimacy—that no one should have their genitals⁵ modified for non-medical reasons without explicit consent. But, it is also for precisely this reason that one can envisage a situation in which a woman has developed sexually with a particular set of infibulated genitals and would wish for those genitals to be recovered post-pregnancy so as to be familiar to her again; so as to be “hers” again. In that situation, I would say that she has a right to such a procedure, which is not at all to say that the state has a responsibility to provide the procedure.⁶

Defending re-infibulation does not imply that the original infibulation was right or good. If it was performed when she was a child, or as an adult but without her consent, or even with her consent against the backdrop of a deeply patriarchal society in which women's bodies are primed to pleasure men, then it is not right,⁷ it is an assault upon her right to bodily autonomy and self-determination. But just because a wrong was done in the past does not mean that it will necessarily be helpful for doctors and lawmakers to “put it right” in the present.

To flatly deny a woman the right to decide to be sewn again is to violate her right to bodily autonomy in much the way it was originally violated. In a strange sense, the second violation may be worse, because whilst the original perpetrators might claim that they acted in the best cultural interests of a young child, for the law to over-rule the choices of

5 Nor any other part of their body, though others, such as pierced ears, carry fewer risks and less social symbolism.

6 That is, it is a negative, rather than positive, right.

7 In the third case, it would be no more or less wrong than the extent to which permanent body hair removal and breast implants are wrong.

a capacitated adult woman is to deny her full adult autonomy, which looks self-defeating if protecting autonomy was its mandate.

That the law says different is so much worse for the law: it is hypocritical in that it infantilises women of particular cultures. Such prejudices cannot reasonably feature in a law that was purportedly introduced to protect the exercise of autonomy; the law has already decided which autonomous decisions will not be permitted! No speculation about the “barbarity” of her upbringing or culture, or the influence of other community members, ought to be enough to militate against her choices regarding her own body.

We can introduce as many laws as we like to protect against FGM, but the context for FGM, like the myriad ways in which women's bodies are regulated and normalised, is consonant with the culture of patriarchy in which we live. An extension of that patriarchy is the widespread idea that Europeans must protect women of colour from the “barbarism” of men of colour[13]. It is from this misled belief that the hypocrisy around FGM stems. UK law codifies the idea that adult women of particular cultures are not as capable of making their own decisions as are other women, let alone as capable as men. For, if a woman requests a labiaplasty (say) from a private cosmetic surgeon in the UK, her ethnicity will likely be used to determine her consent status, and in turn whether or not the procedure can occur legally. The current law enforces differential access to medical procedures on the basis of race.

FGM and medicine

There is no doubt that doctors need firmer guidelines on how to deal with requests for, or evidence of, genital mutilation of minors (of any sex), as this ought to be a child protection issue. All community workers should be equipped to support children who are at risk, and assist families resisting pressure to adhere to oppressive cultural practices. But present legislation merely serves to confuse medical practitioners and other community workers because it is politically loaded and inconsistent. It does not protect all children, and its application to adults remains unjustified. It is inflected with sexism, in treating adult women like minors, and racism, in treating *particular* women like minors, since it does

not apply to FCGS, which patently serves another culture's norms.

Whilst studies [14] [15] show that knowledge of both the practice of FGM and the current legislation is inadequate amongst doctors and midwives, even if all medical professionals understood the law, the fact that it cannot be generated from considerations around child protection and adult capacity precludes the sort of straightforward, intuitive application that is necessary in medical situations, which are typically characterized by urgency, brevity, and complication. Besides, if the law itself is morally problematic, as I have claimed, to push for more rigorous professional ethical guidance around FGM legislation may reduce the confusion without making outcomes any more just (and perhaps, on balance, entrenching injustice).

One can get a sense of this inconsistency and ensuing confusion by comparing UK FGM legislation with the ethical principles used by clinicians as touchstones in exploring the ethics of clinical scenarios. At a glance, it is obvious that the FGM Act contradicts or frustrates the central tenets of clinical ethics, which state that doctors' conduct should be guided by the principles of respect for autonomy, beneficence, non-maleficence, and justice. Adherence to these precepts, or, at the very least, justification according to some interpretation of them, is deemed to constitute good clinical practice. As a rule, good clinical practice aligns with the overarching legal frameworks within which doctors work; the first grounds the second. When this is not the case, the legislation must be assumed to derive from something other than ethics: e.g. prejudices, political agendas, powerful lobby groups.

These principles may be summarised as follows: respect for autonomy rules that patients who have capacity must have their autonomy respected provided they have been adequately informed of risks; beneficence demands that patient safety and wellbeing be prioritized, in full consideration of long term risks and outcomes; non-maleficence urges that clinicians minimise harm, whether short-term or long-term; considerations of justice require that benefits, risks and costs are distributed equitably, and that medically-equivalent patients are treated in equivalent ways. Current FGM legislation conflicts with each of these inter-connected principles.

Adult women have maximal consent capacities in the absence of mitigating factors. Permissible mitigating factors include severe mental health issues, learning disabilities, dementia, or intoxication. Race, ethnicity, nationality and religion are *not* contraindications for consent. Adherence to cultural values does not amount to incapacity, which is just as well, because culture is strongly determinative of most of our decisions. In this case autonomy is not being respected, rather, FGM legislation over-rides the autonomy of a particular group of women whose name, appearance, religion or nationality is deemed to place her under the influence of a uniquely incapacitating culture. As for children, they do not have the capacity to consent to any non-therapeutic modifications of their bodies, therefore their parents should wait until they achieve this capacity to request their consent.

Second, beneficence seems well-placed to justify the criminalization of FGM, but blanket criminalization assumes that all forms of FGM are equally harmful, and always more harmful than male circumcision or FCGS. Many cultures practice varieties of FGM that are more moderate (in terms of both morphological and functional changes) than male circumcision, involving either no tissue removal (merely a prick or nick in the clitoris or labia) or less tissue removal than the entire foreskin, with arguably fewer consequences for sexual satisfaction [16]. At present, beneficence is being applied inconsistently in cases of FCGS, FGM, and male circumcision.

Relatedly, non-maleficence seems at first sight to recommend against all forms of non-therapeutic genital surgery. The extenuating consideration is that preventing a person from adhering to significant cultural norms may itself be a source of harm to that person's wellbeing. Further, criminalization of a culturally-significant procedure precludes the regulation of the procedure, likely resulting in unsafe practices which cause greater medical harms. These considerations apply equally to FGM, male circumcision, and FCGS, therefore the non-maleficence heuristic must be applied equivalently across all non-therapeutic genital surgeries.

Finally, justice is violated in the inequitable implementation of each of the aforementioned principles. While distributive justice is not so important, since there is no

expectation that these procedures would be performed using state resources (rather, they would be limited to the private sector), there is a very serious violation of the principle of equity. Current legislation does not afford equal access to moderate forms of non-therapeutic genital surgery as a way of meeting important social norms, as well equal access to the health and safety protections afforded by regulation.

Taking each in turn: the autonomy of some competent adult women is being denied; there is a limit to beneficence in that: (a) for FGM in adults, doctors are not able to weigh the preferences of the patient when deciding whether to carry out the procedure, while (b) in the case of male circumcision for babies, doctors are not able to preserve the future adult's right to choose; doctors cannot fulfil their role of non-maleficence by avoiding the enforcement of harms upon children who are subject to male circumcision; the law obliges doctors to impose unjust differential treatment on their patients, in terms of sex and ethnicity.

In other words, if a clinician begins with the principles of medical ethics, she will surely conclude that either: (a) non-therapeutic genital surgeries should be legally available to *all capable consenting* adults, subject to clinical regulation, in the awareness that an inability to meet social norms may cause harm; or (b) *no* non-therapeutic genital surgeries should be performed, since all carry risks, and although this would be a violation of autonomy, it would cohere with the fact that autonomy tends to be a negative right (to not be interfered with) rather than a positive right (to receive desired treatments). And regardless of which of (a) or (b) seems most morally compelling, a clinician considering the four principles of medical ethics would undoubtedly maintain the view that (c) no child may have non-therapeutic modifications made to her/his body, especially those that are irreversible (i.e. involving tissue damage/removal).

It is therefore clear that the law cannot be derived from medical ethics without the addition of questionable and arbitrary premises about whether and which women count as decisionally-capable adults. To whatever extent laws are supposed to reflect the ethics for which they advocate (c.f. Jackson [17]), it seems that something is awry.

In short, while doctors should be expected to carefully consider the nuances of each moral

situation as it arises, and take note of the particularities that arise due to the social-situatedness of each individual patient, they should expect the laws that govern their actions to be derivable from good medical practice, which is in turn computed by consideration of what is right and just, as determined by ethics. In clinical practice there should be no place for intractable confusion, and ethical situations present sufficient confusion in the first place without the covert addition of questionable ideological agendas. As it is, UK doctors face their own injustice: the disproportionately high stakes when it comes to legal reprisals around FGM due to this mystifying legislation, a framework that is easily seen to be inconsistent, unfair, and even oppressive. Asking clinicians to operate against such a backdrop of opaqueness and fear is not acceptable when the straightforward facilitation of patient safety and autonomy should be their unfettered priorities.

Conclusion

The obstetrician in question stood trial because he had evidently broken the law, which can only be deemed an ethical shortcoming to the extent that the FGM Act is considered to be just. I do not believe that it is. First, it is too weak. Whilst it seems adequate to protect female children from non-therapeutic genital surgery, it does nothing to protect male children. Yet it is also too strong. It forbids some women of colour from particular kinds of genital surgery, since the pressures of their presumed culture are deemed to invalidate their ability to act autonomously. Meanwhile, it permits other women to undergo broadly similar procedures because *their* cultures are deemed to be inexplicably causally irrelevant to their life choices. In this sense, UK FGM legislation embodies discourses of sexism and ethnocentrism. I see this as a failure of self-critique on the part of British lawmakers, who would do well to pass a critical eye over the punishing ways in which sexism operates on women's bodies in the UK and other Western contexts.

In light of these reflections, I suggest that the scope of this law be *extended* to include all forms of non-therapeutic genital surgery for all children. A “genital mutilation Act”, dovetailing with broader child protection legislation, could apply to the bodies of all those below the age of consent, including: FGM, male circumcision, and even non-therapeutic intersex genital surgeries. Further, the current legislation should also have its scope

restricted so that capacitated adult women are not included. The first recommendation would treat children of all sexes as alike in their right to bodily protection; the second recommendation would treat all adult women alike in their right to consent to bodily modifications. The extent of those bodily modification as permitted by medical practice guidelines is another matter entirely, but given the trends in FCGS, it seems that some forms of FGM would be *de facto* available. Implementing these reforms would provide practitioners with a consistent backdrop against which to make their clinical decisions regarding non-therapeutic genital surgeries.

Of course, medicalising FGM for adult women runs the risk of normalising the practice. Yet even for a consenting adult, there is no good reason to provide such services on the National Health Service, since they do not amount to the treatment or correction of a disease. But equally, there is no reason to ban them from private clinics, since they do not differ from other forms of genital cosmetic surgery—they share a family-resemblance in the oppression they represent, and carry similar risks under similar conditions—and they bear striking similarities to male circumcision, which has never been legislated against. Further, consideration must presumably be given to the risk and humiliation incurred should a woman decide to have these procedures performed in a non-medical context.

To those who worry that such amendments would leave women more vulnerable to misogynistic practices, I ask that they turn their efforts to the many movements, across *all* cultures, to tackle the way in which patriarchy delimits women's lives along lines that make practices such as FGM and FCGS possible and even meaningful. They should also bear in mind that if, in this process, women's voices are ignored, or their choices consistently over-ruled, side-lined, or pre-determined, even under the guise of “beneficence,” the entire enterprise is undermined.

All children who undergo FGM, and those women who are coerced, have their agency limited by their communities. They are objectified by the patriarchal mores which dictate how their bodies should be in relation to the roles they must play. The additional denial of agency from policy makers and medical professionals, who have dictated that these women's genitals should (post-pregnancy) be “restored”—albeit passively—to pre-FGM genitals regardless of the woman's wishes quite literally adds insult to injury. They too are

dictating how a woman's genitals should be presented.⁸ In neither case is an adult woman being permitted to determine how her own intimate body parts should be.

To enforce the current UK law on FGM as it relates to adult women is to gloss over the very ethical issues that put FGM into the centre of an ethical debate to start with (namely, challenging patriarchy and protecting bodily autonomy) and to selectively punish particular cultures for their practices, while leaving functionally equivalent practices as sacrosanct. It is to assert a particular set of Eurocentric norms on women with no consideration for their own relationships with their bodies and with limited understanding of how they use those bodies within their communities. It is further to demonstrate enormous hypocrisy when FGCS is showing an upward trend in the private medical sector, [19], with no laws to stem the tide, and when the rich and growing literature on the ethical issues with male circumcision (c.f. Earp [20], Myers [21], Johnson [22]) is yet to translate into serious professional reflection⁹ or legal reform.

Abbreviations FGM, female genital mutilation; FGCS, female genital cosmetic surgery.

Funding This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors

Competing interests None.

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⁸ Njambo [18] discusses the way in which much of the anti-FGM discourse relies on an uncritical sense of what constitutes a “natural” body.

⁹ Not so in the Netherlands, where the Royal Dutch Medical Association released a position paper in 2010 [23] which described male circumcision as medically unjustifiable, risky, and a violation of autonomy and physical integrity. The paper argued that legal prohibition is defensible, but that restriction, at the very least, should be considered.

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