I try not to talk about my research at dinner parties. I’ll say “medical ethics” if pressed, which will sometimes trigger an unwelcome follow-up: “But what about medical ethics? That’s a pretty big field.” “I study lots of things,” I’ll say—and that’s true, I do. “But I focus on medically unnecessary surgeries performed on children.”

“Like what?”

Like what, indeed. It’s rarely a smooth ride from there.

The truth is: I study childhood genital surgeries. Female, male and intersex genital surgeries, specifically, and I make similar arguments about each one. As a general rule, I think that healthy children—whatever their sex or gender—should be free from having parts of their most intimate sexual organs removed before they can understand what’s at stake in such a procedure. There are a number of reasons I’ve come to hold this view, but in some ways it’s pretty simple. “Private parts” are private. They’re personal. Barring some serious disease to treat or physical malfunction to address (for which surgery is the most conservative option), they should probably be left alone.

That turns out to be extremely controversial.

In the 1990s, when the Canadian ethicist Margaret Somerville began to speak and write critically about the non-therapeutic circumcision of infant boys, she was attacked for even addressing the subject in public.

In her book The Ethical Canary, she says her critics accused her of “detracting from the horror of female genital mutilation and weakening the case against it by speaking about it and infant male circumcision in the same context and pointing out that the same ethical and legal principles applied to both.”

She wasn’t alone. The anthropologist Kirsten Bell has advanced similar arguments in her university lectures, provoking a reaction that was “immediate and hostile... How dare I mention these two entirely different operations in the same breath! How dare I compare the innocuous and beneficial removal of the foreskin with the extreme mutilations enacted against females in other societies!”

It’s easy to see where these reactions are coming from. One frequent claim is that FGM is analogous to “castration” or a “total penectomy.” Put that way, anyone who tried to compare the two on ethical (or other) grounds would be making a serious mistake—anatomically, at the very least.

You often hear that genital mutilation and male circumcision are very different. FGM is barbaric and crippling (“always torture,” as the Guardian columnist Tanya Gold wrote recently), whereas male circumcision is comparatively inconsequential. Male circumcision is a “minor” intervention that might even confer health benefits, whereas FGM is a drastic intervention with no health benefits, and only causes harm. The “prime motive” for FGM is to control women’s sexuality; it is inherently sexist and discriminatory and is an expression of male power and domination. That’s just not true for male circumcision.

Unfortunately, there’s a problem with these claims. Almost every one of them is untrue, or severely misleading. They derive from a superficial understanding of both FGM and male circumcision; and they are inconsistent with what scholars have known about these practices for well over a decade. It’s time to re-examine what we “know” about these controversial customs.

The World Health Organization (WHO) defines FGM as any “non-medical” alteration of the genitalia of women and girls. What this is likely to bring to mind is the most extreme version of such “alteration,” which is the excision of the external part of the clitoris followed...
by a narrowing of the vaginal opening, sometimes using stitches or thorns. It is rarely understood that this notorious form of FGM is comparatively rare: it occurs in a subset of the practicing communities, and makes up about 10 per cent of cases worldwide. More prevalent, but much less frequently discussed in the media, is a range of less extensive alterations, sometimes performed under anesthesia by medical professionals and with sterile surgical equipment. These include, among other interventions, so-called ritual “nicking” of the clitoral hood (common in Malaysia), as well as non-medically-indicated labiaplasty and even piercings that might be done for perceived cosmetic enhancement.

It should be clear that these different forms of FGM are likely to result in different degrees of harm, with different effects on sexual function and satisfaction, different chances of developing an infection, and so on. And yet all forms of non-therapeutic female genital alteration—no matter how sterilized or minor—are deemed to be mutilations in ‘Western’ countries. All are prohibited by law. The reason for this, when you get right down to it, is that cutting into a girl’s genitals without a medical diagnosis, and without her consent, is equivalent to criminal assault on a minor under the legal codes of most of these societies. And, morally, I think the law is correct here. I don’t think that a sharp object should be taken to any child’s vulva unless it is to save her life or health, or unless she has given her fully informed permission to undergo such an operation, and wants to take on the relevant risks and consequences.

In that case, of course, she wouldn’t be a “child” anymore, but rather an adult woman, who can make a decision about her own body.

The story is very different when it comes to male circumcision. In no jurisdiction is the practice prohibited, and in many it is not even restricted. In some countries, including in the United States, anyone, with any instrument, and any degree of medical training (including none) can attempt to perform a circumcision on a non-consenting child—sometimes with disastrous consequences. For a recent example, look up “Goodluck Cauaerts” on the internet; similar cases happen every year. As the bioethicist Dena Davis has pointed out, “States currently regulate the hygienic practices of those who cut our hair and our fingernails... so why not a baby’s genitals?”

Just like FGM, however, circumcision is not a monolith: it isn’t just one kind of thing. The original Jewish form of circumcision (until about AD150) was comparatively minor. It involved cutting off the overhanging tip of the foreskin—whatever stretched over the end of the glans—therby preserving (most of) the foreskin’s protective and sexual functions, as well as reducing the amount of erogenous tissue removed. The “modern” form is much more invasive: it removes between one-third and one-half of the movable skin of the penis (about 50 square centimeters of richly innervated tissue in the adult organ), eliminates the gliding motion of the foreskin, and exposes the head of the penis to environmental irritation, as it rubs against clothing.

Male genital cutting is performed at different ages, in different environments, with different tools, by different groups, for different reasons. Traditional Muslim circumcisions are done while the boy is fully conscious, between the ages of five and eight, and sometimes later. American (non-religious) circumcisions are done in a hospital, in the first few days of life, with or without an anesthetic. Metzitza b’peh, done by some ultra-Orthodox Jews, involves the sucking of blood from the circumcision wound, and carries the risk of herpes infection and permanent brain damage.

Subincision, seen primarily in Aboriginal Australia, involves slicing open the urethral passage on the underside of the penis from the scrotum to the glans, often affecting urination as well as sexual function. And circumcision among some tribal groups in Africa is done as a rite of passage, in the bush, with spearheads, dirty knives, and other non-sterile instruments. Similar to female genital cutting rities performed under comparable conditions (and often by the very same groups), these operations frequently cause hemorrhage, infection, mangled, and loss of the sexual organ. In fact, between 2008 and 2014, more than half a million boys were hospitalized due to botched circumcisions in South Africa alone. More than 400 lost their lives.

But even “hospitalized” or “minor” circumcisions are not without their risks and complications, and the harm is not confined to Africa. In 2011, for example, nearly a dozen infant boys were treated for life-threatening hemorrhage, shock or sepsis as a result of their non-therapeutic circumcisions at a single children’s hospital in Birmingham, England. Since this figure was obtained by a special freedom of information request (and otherwise would not have been public knowledge), it has to be multiplied by orders of magnitude to get a sense of the true scope of the problem.

When people talk about “FGM” they are usually thinking of the most severe forms of female genital cutting, done in the least sterile environments, with the most drastic consequences likely to follow—even though research suggests that these forms are the exception rather than the rule. When people talk about “male circumcision,” by contrast, they are (apparently) thinking of the least severe forms of male genital cutting, done in the most sterile environments, with the least
drastic consequences likeliest to follow—perhaps because this is the form with which they are culturally familiar.

One recurrent claim, recently underlined by the US Centers for Disease Control (CDC), is that male circumcision can confer a number of health benefits, such as a small reduction in the absolute risk of contracting certain sexually transmitted infections. This is not typically seen as being the case for FGM.

However, both parts of this claim are misleading. Certainly the most extreme types of FGM will not contribute to good health on balance, but neither will the spearheads-and-dirty-knives versions of genital cutting on boys. What about other forms of FGM? Its defenders (who typically refer to it as “female circumcision”) regularly cite such “health benefits” as improved genital hygiene as a reason to continue the practice. Indeed, the vulva has all sorts of warm, moist places where bacteria or viruses could get trapped, such as underneath the clitoral hood, or among the folds of the labia; so who is to say that removing some of that tissue (with a sterile surgical tool) might not reduce the risk of various diseases?

Fortunately, it’s impossible to perform this type of research in the West, because any scientist who tried to do so would be arrested under anti-FGM laws (and would never get approval from an ethics review board). So we simply do not know. As a consequence of this, every time one sees the claim that “FGM has no health benefits”—a claim that has become something of a mantra for the WHO—one should read this as saying, “we actually don’t know if certain minor, sterilized forms of FGM have health benefits, because it is unethical—and would be illegal—to find out.”

By contrast, a small and consistent group of (mostly American) scientists have taken it upon themselves to promote infant male circumcision as a form of partial prophylaxis against disease. Most of these diseases are rare in developed countries, do not affect children before an age of sexual debut, and can be prevented and/or treated through much more conservative means. Nevertheless—since it is not against the law for them to do so—advocates of (male) circumcision are able to conduct study after well-funded study to see just what kinds of “health benefits” might follow from cutting off parts of the penis.

Many European medical experts dispute these studies, and detect more than a whiff of cultural bias in favor of circumcision due to its peculiar status as a birth ritual in American society. The recent statement by the CDC is a case in point. This otherwise august organization contends that the benefits of circumcision outweigh the risks, where by “risk” they apparently mean “risk of surgical complications.”

But in medical ethics, the appropriate test for a non-therapeutic surgery performed in the absence of disease or deformity is not benefit vs “risk of surgical complications” but rather benefit vs risk of harm. In this case, one relevant harm would be the involuntary loss of a healthy, functional, and erotogenic genital structure that one might wish to have experienced intact. Imagine a report by the CDC referring to the benefits of removing the labia of infant girls, where the only morally relevant drawback to such a procedure was described as the “risk of surgical complications.”

It is often said that FGM is designed to “control” female sexuality, whereas male genital cutting is less symbolically problematic. But as the sociologist Lisa Wade has shown in her research, “attributing [the] persistence [of female genital altering rituals] to patriarchy grossly over-simplifies their social, cultural, and economic functions” in the diverse societies in which they are performed. Throughout much of Africa, for example, genital cutting (of whatever degree of severity) is most commonly performed around puberty, and is done to boys and girls alike. In most cases, the major social function of the cutting is to mark the transition from childhood to adulthood, and it is typically performed as part of an elaborate ceremony.

Indeed, in nearly every society that practices such coming of age rituals, the female half of the initiation is carried out by women (rather than by men) who do not typically view it as being a consequence of male dominance, but who instead see their genital-altering practices as being beautifying, even empowering, and as an important rite of passage with high cultural value. The claim that these women are all “brainwashed” is anthropologically ignorant. At the same time, the “rite of passage” ceremonies for boys in these societies are carried out by men; these are done in parallel, under similar conditions, and for similar reasons—and often with similar consequences for health and sexuality (as illustrated earlier with the example of South Africa).

In the US context, male circumcision was adopted by the medical community in the late 1800s in an effort to combat masturbation, among other dubious reasons. It has since persisted as a rationalized habit, long past the time when it was effectively abandoned by other developed nations. Of course, it is probably true that most contemporary Western parents who choose circumcision for their sons do not do so out of a desire to “control” their sexuality, but this is also true of most African parents who choose “circumcision” for their daughters. As the renowned anti-FGM activist Hanny Lightfoot-Klein has stated: “The [main] reasons given for female circumcision in Africa and for routine male circumcision in the United States are essentially the same. Both
promise cleanliness and the absence of odors as well as greater attractiveness and acceptability."

Given that both male and female forms of genital cutting express different cultural norms depending upon the context, and are performed for different reasons in different cultures, and even in different communities or individual families, how shall we assess the permissibility of either? Do we need to interview each set of parents to make sure that their proposed act of cutting is intended as an expression of acceptable norms? If they promise that it isn’t about “sexual control” in their specific case, but rather about “hygiene” or “aesthetics” or something less symbolically problematic, should they be permitted to go ahead?

But this is bound to fail. Every parent who requests a genital-altering surgery for their child—for whatever reason under the sun—thinks that they are acting in the child’s best interests; no one thinks that they are “mutilating” their own offspring (whether female or male). So it is not the reason for the intervention that determines its permissibility, but rather the consequences of the intervention for the person whose genitals are actually on the line.

As the social anthropologist Sara Johnsdotter has pointed out, there is no one-to-one relationship between the amount of genital tissue removed (in males, females, or indeed in intersex people), and either subjective satisfaction while having sex, or a feeling of having been personally harmed because one’s “private parts” were altered before one could effectively resist. Medically unnecessary genital surgeries—of whatever degree of severity—will affect different people differently. This is because each individual’s relationship to their own body is unique, including what they find aesthetically appealing, what degree of risk they feel comfortable taking on when it comes to elective surgeries on their reproductive organs, and even what degree of sexual sensitivity they prefer (for personal or cultural reasons). That’s why ethicists are beginning to argue that individuals should be left to decide what to do with their own genitals when it comes to irreversible surgery, whatever their sex or gender.

This article is adapted from a longer piece originally published at the University of Oxford’s Practical Ethics website. Links to supporting research can be found in the original essay, available here: https://www.academia.edu/8817976/Female_genital_mutilation_FGM_and_male_circumcision_Should_there_be_a_separateethical_discourse