ON THE COVER
Agama Mani, Georgetown University Medical School, Single Brushstroke. Oil on paper. 22.9 × 30.5 cm.

THE PROBLEM OF FEMALE GENITAL MUTILATION (FGM) INSPIRED NEARLY 100 medical students from 3 continents to submit their work for the 2002 John Conley Ethics Essay Contest for Medical Students. Essayists discussed ethical issues that would arise if an 18-year-old woman requested that a surgeon in the United States perform FGM on her before she returned home to Africa, where FGM is most commonly practiced. Also known as “female genital cutting” and “female circumcision,” FGM includes 4 types according to a classification scheme delineated by the World Health Organization in 1995. The classification is based on increasingly extensive excisions of the genitalia from types I to type III, with types I and II comprising the majority of procedures. Variations of FGM that do not meet the criteria for the first 3 types are classified as type IV.

The young woman in the scenario requested that the surgeon perform type III, or infibulation, which is the most surgically extensive form of FGM. Type III includes an excision of part or all of the external genitalia and stitching of the vaginal opening, and has been associated with the most serious health complications.

Ninety-five percent of FGM is performed on girls between one day to 16 years old, particularly between the ages of 4 and 10 years. However, some cultures perform FGM into adulthood, such as at the time of marriage. Thus, the patient in this scenario requested to have the procedure performed at a relatively old age.

According to the scenario, the woman wanted the surgery before returning to her homeland in order to decrease her risk of complications that may occur as a result of having it done under unsterile and relatively primitive conditions. The literature on the health risks associated with FGM has mostly focused on gynecologic problems such as hemorrhage, infection, and dysmenorrhea. Other health-related parameters such as overall mortality and morbidity have yet to be documented thoroughly, and the data on which advocates have argued against FGM have been criticized for not meeting rigorous scientific standards of evidence. Nevertheless, national and international health and government organizations have taken strong stands against the practice, arguing that the currently available data sufficiently document the dangers of FGM.

The winning essays in this year’s contest explore ethical, moral, and professional dilemmas raised by considering whether or not to perform FGM. Peter Moschovis argues that FGM is wrong because it violates universal moral values and harms the patient-physician relationship overall. Also arguing against FGM, Kyle Brothers challenges physicians to consider relating to their patients as covenant partners whose voices deserve to be heard. Natalie Moniaga makes the case that a surgeon opposed to FGM can still perform the procedure without contradicting his or her values. And finally Sara Cichowski relates a fictional dialogue between a young woman requesting FGM and the surgeon whom she asks to perform the procedure. Cichowski based the dialogue on an actual encounter she had with a young woman who requested a similar procedure.

We thank this year’s judges—Jeffrey Botkin, MD, MPH, Sally Sheldon, PhD, and Sidney Wolfe, MD.
When Cultures Are Wrong

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She cut everything—she didn’t cut the big lips, but she sliced off my clitoris and the two black little lips, which were haram—impure—all that she sliced off like meat. Oh, Rahima, I thought I was going to die. . . . She sliced the top off my big lips and then she took thorns like needles and put them in crossways, across my vagina, to close it up.

These are the words of Aman, a Somali woman, recounting her childhood experience of circumcision. In her 1994 autobiography, she weaves a story of growing up at the interface between her native Somali culture and Western colonialism. The dilemma of circumcision is a microcosm of the clash of cultures in Aman’s life. Like many women from tradition-centered cultures, Aman is torn between a profound sense of cultural loyalty and a commitment to a life of freedom and empowerment. The meaning that she derives from her culture is central to her self-image as a woman, but the experience is profoundly traumatic. The tension that arises from Aman’s experiences can be extended to the broader question of the ethics of female genital mutilation (FGM).

Estimates confirm that Aman’s experiences are common. In 1998 the World Health Organization estimated that more than 135 million girls and women had undergone some form of FGM, and 2 million girls are at risk each year. The practice is most widespread in Africa; in some countries as many as 97% of all women have been circumcised. In addition, FGM has become increasingly common in immigrant and refugee populations in Western Europe and North America. A landmark 1997 joint statement of the World Health Organization, UNICEF, and the UN Population Fund defined four types of genital mutilation. Based on this classification, Aman and the African woman in this case underwent type III FGM, which is the most radical form of genital cutting. The associated physical complications range from minor to severe for all types of FGM.

Common postoperative complications include urinary and reproductive tract infections, dysmenorrhea, and hemorrhagic shock. Longer term complications of type III FGM include failure to heal, urinary retention or incontinence, dermoid cysts, urinary and reproductive tract infections, and dysmenorrhea. Several cases have been documented of girls bleeding to death after physicians performed the procedure, casting doubt on the assertion that the sequelae are less severe if a physician performs FGM instead of a midwife. The most frequent complication of FGM is the diminishing of the woman’s sexual pleasure and libido. Infibulated women often require the scar to be cut open on their wedding night, especially if their husbands are unable to penetrate the small opening that remains. Some women ask to be reinfibulated after each childbirth, having the separated edges sewn back together.

FGM is not practiced in a cultural vacuum. Virtually every culture that embraces FGM carries it out in the context of an elaborate ceremony, which for many is a mark of initiation into womanhood. An uncircumcised woman may be viewed by peers and potential spouses as less of a woman, unclean, and disloyal to her culture. As a result, women and midwife practitioners are often among the strongest proponents of the practice. In many cases, the ritual is associated with a woman’s religious identity. One popular mythological justification for the circumcision of both men and women is the belief that the male prepuce and female clitoris represent feminine and masculine elements, respectively, and must be excised to prevent gender confusion. “The clitoris of the girl is in fact a symbolic twin, a male makeshift with which she cannot reproduce herself, and which, on the contrary, will prevent her from mating with a man,” explains Ogotemméli, an elder of the Sudanese Dogon people. Since FGM may diminish libido, many see the procedure as a means of preventing promiscuity. Another Dogon leader contends that “The uncircumcised think of nothing but disorder and nuisance.”

These accounts illustrate the profound meaning that FGM can carry for those who undergo it. They cannot, however, answer the question of whether a physician has the right to pass moral judgment on his or her patient’s choices, especially when they are informed by deeply held cultural values.

The principle of autonomy mandates that physicians respect their patients’ right of self-determination: their care must parallel patients’ values, interests, and desires. Because these factors are to a large extent culturally constructed, physicians are obligated to respect cultural differences and, when possible, to honor and even to learn from them. The extreme of this perspective—cultural relativism—holds that all cultures and their practices are equally valid, and that it is improper to pass judgment on another culture. Respect for this patient’s autonomy and culture, however, does not preclude condemning the practice of genital mutilation. Even within societies that practice FGM, a plurality of views exists. Deconstructionists have argued that no culture is completely uniform, noting that policymakers often consider the voices of the powerful few while ignoring the voices of the oppressed. A recent study in central Sudan indicates a growing disenchantment with the practice among younger mothers, a moral flux that is important in informing discussion of FGM.

Even a cultural relativist can use the internal standards of a culture to point out the questionable character of a tradition. For example, Islam does not condone FGM, and the practice antedates the arrival of Islam to African countries. Reference to cultural values that the woman already accepts allows the physician to develop an “argument from within” against the practice.

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By making use of the principles that inform a patient’s world view, a physician can often persuade the patient to adopt an alternate course of action. Furthermore, strong international precedents exist in making judgments about the ways other cultures have treated women. Examples include the Western opposition of sex slavery in Eastern Europe, the mass rapes of Bosnian women in the last decade, and prenatal sex selection and female infanticide in China. Western influences also played an important role in the eradication of Chinese foot binding. A rejection of cultural relativism, however, is insufficient justification for refusing to treat the patient.

The necessary added ethical force comes from the fundamental moral mandates of medicine: doing good and avoiding harm. Ethical debates about privacy rights, autonomy, and health care allocation are far from settled. However, doing good and avoiding harm form the foundation of the practice of medicine. While the specifics of beneficence and nonmaleficence certainly vary by culture and clinical context, these two principles give physicians the right—a fundamental moral mandate of medicine: doing good and avoiding harm. Ethical debates about privacy rights, autonomy, and health care allocation are far from settled. However, doing good and avoiding harm form the foundation of the practice of medicine. While the specifics of beneficence and nonmaleficence certainly vary by culture and clinical context, these two principles give physicians the right to withhold treatment that they consider harmful to patients.

The physician must sensitively and respectfully engage the patient in a discussion of values, eliciting contributing facts that elucidate the values underlying the available options. In this way, the physician can both honor the patient’s culture while gently presenting his or her own moral perspective. Ultimately, the only direct control that physicians can exert is over whether they will personally perform the procedure. They cannot dictate their patients’ actions. As Aman says, “If Somali women change, it will be a change done by us, among us. . . . To advise is good, but not to order.”

Carrying out this sort of dialogue does not diminish the difficulty of the dilemma. On the contrary, the stakes remain high, since refusing to perform the procedure may result in future harm to the patient if she develops complications by having the procedure performed in her homeland. But this potential harm must be viewed in the context of the patient-physician relationship, since performing the procedure will not only affect the individual patient’s health, but alter the patient-physician dynamic overall.

Performing FGM sets a dangerous precedent in the professional relationship and may obligate the physician to provide future interventions that he or she considers improper, frivolous, or harmful. Physicians ultimately gain credibility by refusing to provide services that they deem unnecessary and detrimental, such as prescribing antibiotics for viral infections, even if their patients demand them. In addition, physicians who perform FGM, even while attempting to persuade patients otherwise, implicitly sanction the practice. While cultural relativists argue that a detached, nonjudgmental stance allows physicians to shift the ethical burden onto their patients, experience shows that this moral distance is artificial and impossible to maintain. The patient-physician relationship is based on a patient’s trust that the physician is committed to the patient’s best interest. When the physician compromises this commitment explicitly by providing medically unnecessary procedures, or implicitly by offering such services, the relationship suffers.

The central ethical tool for difficult decisions is the dialogue itself, for it acknowledges the need of both individuals to learn from one another. Physicians must listen to their patients and attempt to enter into their patients’ framework of values as much as possible. In this context of shared moral reasoning, they can learn from the insights of their patients while contributing their own perspectives. By combining humility, respect, and commitment to the patient’s good, a physician can remain true to the principles of multiculturalism and justice while maintaining an ethically sound position.

REFERENCES
Covenant and the Vulnerable Other

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At its best, the patient-physician relationship is not simply a contract, but a covenant. Unlike a contract, the focus of a covenant is not on rigid duties and obligations, but on what the two parties can achieve together to optimize the patient’s health. The physician’s responsibility is to respond with commitment, empathy, and creativity, especially when the patient’s health is at risk, as in the case of the 18-year-old female African patient.

In Covenant, Community, and the Common Good, Eric Mount builds on a Jewish philosophical tradition to describe the way a covenant relationship can accommodate the “vulnerable other.”1 Like the groups that Mount discusses, the stranger, the fatherless, the poor, and the widow, this woman is vulnerable in that she may face considerable harm if left to confront her situation alone. Because this patient’s experience of the world is so different from that of the physician, he or she may misperceive the patient’s beliefs and attitudes. Due to this “otherness,” her world is “accessible only to the extent that genuine dialogue occurs.”

The difference between the cultures of the physician and the patient is a specific type of “otherness” that poses a considerable threat to communication. Many argue that applying Western concepts of feminism, sexuality, and human rights ignores the cultural values of the societies that participate in female genital mutilation (FGM). For example, Sudanese women may view infibulation as an “assertive, highly meaningful act that emphasizes female fertility by de-emphasizing female sexuality.”2 However, it would be a mistake to assume that this patient supports the practice of FGM. There are wide variation in the beliefs of African women about this practice, and this patient’s time in the United States may have further altered her perspective.

The physician must engage in a dialogue with the patient to discover her perceptions of FGM within her own community. I will consider 2 opposing responses to the question “What are your own beliefs about female circumcision?” to illustrate issues that may arise.

Response 1: I don’t want to have the surgery! Please help me get out of this situation! This is a call to action to the physician, who could respond by referring her to African groups that work to replace or eliminate FGM. One project in Kenya offers a “noncutting ritual event” as a replacement for coming of age ceremonies involving FGM. If similar programs exist in the patient’s home country, they might be a viable option. Referral to such a group could provide the patient with support and may allow her to avoid infibulation altogether. This simple step would empower the patient and help her to reclaim her autonomy. However, the patient might reply that she will nonetheless be obligated to undergo FGM to avoid ostracism and to be eligible for marriage. If she experiences this obligation as a form of coercion, the physician could help the patient to explore options such as political asylum.3

Response 2: Female circumcision is a tradition of my people, and I will not stray from it. In this case, the physician must realize that beliefs or values considered irrational in one culture may be rational in another, and remember that patients have the right to make informed decisions about their health. Regardless of his or her personal views, the physician needs to provide impartial information about different types of FGM procedures and the risks associated with them. The physician must also consider the legal, professional, and personal consequences of performing FGM. Physicians performing this procedure in the United States might face prosecution, since FGM is considered to be a form of assault under federal and state laws.4,5

Simply refusing to perform FGM would do nothing to resolve the patient’s dilemma. The special covenant relationship requires that the physician offer alternatives to the patient. For instance, the physician could help the patient investigate the availability of trained health professionals who are willing to perform FGM under sterile conditions in her home country. Mandara6 discusses the results of interviews with 250 Nigerian physicians, 20% of whom supported the medicalization of FGM, suggesting that this patient may find a similar alternative once she returns home.

A dialogue between the patient and physician is the foundation of providing a satisfactory response to the patient’s status as the vulnerable other. What begins as an ethical quandary can then serve to provide empowerment to the patient. In the end, the vulnerable other is made less vulnerable, and opportunity is found in her otherness.

REFERENCES
A Woman’s Rite to Health

Natalie Catharine Moniaga, Keck School of Medicine, University of Southern California, Los Angeles

Physicians take an oath to do no harm. Traditionally defined as physical injury, “harm” has grown to include aspects of social and emotional well-being. For a patient requesting genital cutting, harm must be considered both in terms of her physical outcomes and cultural ideals.

Opponents of female genital mutilation (FGM) view the procedure as a form of violence against women and equate it with rape, domestic violence, child abuse, and female infanticide. While associated with many medical problems, FGM usually signifies passage into the social, familial, sexual, and reproductive roles of womanhood. Genital cutting has even symbolized a celebration of normalcy in places such as Sierra Leone, where civil unrest had once disrupted the practice. In 1997, approximately 600 women underwent FGM to commemorate the end of that country’s civil war and as a show of the country’s new found solidarity.

Physicians must also consider the medical and social implications of FGM. Beauchamp and Walters argue that informed, autonomous, and competent adults have the right to hold views, make choices, and take actions based on their values and beliefs. Nonetheless, US Federal Law PL 104-20821 makes the practice of FGM on anyone younger than 18 years a crime. Furthermore, several organizations oppose the practice of FGM, citing numerous negative sequelae. However, the data on which such claims are based are largely confined to anecdotal case reports without comparison groups. One recent study found that different types of genital cutting are associated with different levels of risk for future gynecological or obstetric complications. Another found that commonly cited negative sequelae were not significantly more common in women who underwent type II FGM.

One harm-reduction strategy is to medicalize FGM by having trained practitioners perform the procedure under sterile conditions. Opponents of medicalization argue that FGM is unacceptable even under sterile conditions because it would not prevent many of the long-term health consequences and that such medicalization would legitimize the procedure. Proponents of medicalization counter that FGM is already viewed as legitimate by those who believe in it and that not medicalizing it would endanger the health and lives of women.

Denying FGM in this case will not necessarily protect the patient from harm, as she is likely to undergo the procedure in her homeland, with increased risk of infection and other complications. In returning home, the patient is choosing to abide by the norms of her culture. She may not view herself as a victim in need of protection and may actively wish to undergo the rite. Physicians must not pass judgment on the customs of their patients’ cultural practices, especially when the alternative may cause harm by cultural alienation and social exclusion.

A physician cannot protect this patient from the negative consequences of undergoing FGM in her homeland. However, a physician may provide some protection by performing the surgery before she returns home. This may be a sound and compassionate approach to improving the patient’s health, but should be done in conjunction with the traditional rituals associated with it. Providing FGM without regard to its meaning would defeat the patient’s desire to undergo the surgery as a cultural rite.

Organizations that oppose the medicalization of FGM argue that only eradication of FGM can protect the patient’s health. But legislative and institutional censure of the practice may actually be harmful if the practice is pushed underground. Rather than joining in the effort to ban FGM, physicians must educate their patients about its health risks and develop support structures in which their autonomy could be used to make healthful decisions. However, physicians should not be required to perform a procedure they personally consider to be wrong.

FGM can only be eradicated when the quality of life for women is raised by resolving other problems such as poverty, the effects of war, unemployment, discrimination, lack of education and health care, and women’s poor legal status. Until then, physicians must educate their patients and work to minimize the physical, emotional, and social harms to which they are subjected.

REFERENCES

Beatrice’s Choice

Sara Cichowski, University of Washington School of Medicine, Seattle

BEATRICE DID NOT GREET ME AS I WALKED INTO THE EXAM ROOM, and I knew something was wrong. “I’m worried. I only think about one thing,” she began. “When I return to Sudan I must be circumcised. But I fear the pain, and I have seen infection kill my cousins. I want you to perform my circumcision.”

Almost before the magnitude of her request hit me, an excuse leaped out of my mouth, “But I don’t do that—I’ve never performed a female circumcision before.”

“But you can help me,” she replied quietly.

“Who told you that you must be circumcised?” I wondered aloud.

“I told myself that I must be circumcised.” Beatrice answered.

“But do you want to be circumcised?” I challenged, hoping that someone forced this on her.

“I cannot carry my head proudly if I return to my people uncircumcised and unmarried at 18. They’ll laugh,” she explained.

“Beatrice, I can’t consent to do a surgery on you that I do not know you have chosen. Is it your desire to be circumcised?” I asked.

“Americans value their personal choices. The right to choose overwhelms me. Our ways, our people, our culture will disappear if we do not let our ancestors choose our path. I have known my choice since being a little girl. As little girls, we played by pretending that our turn had come. What will be said of me if I am not circumcised?”

“Yes, but I will cause you pain and . . .” I argued, but Beatrice interrupted, “Doctor, that pain is my duty to bear as a woman.”

I explained that I was unwilling to surgically remove parts of her body without medical cause. I was frustrated that she could not see the violation of this procedure nor the bondage of being marked as tribal property. Incredulous, but wanting to understand her perspective, I asked why she wanted the circumcision.

“I want a man from my tribe to marry me,” Beatrice explained, “and no decent man will take me as his bride now. After circumcision, I will please my husband. If I refuse, my father will not receive the bride price he deserves. Circumcision will mark me as a woman.”

She saw two choices: circumcision performed by me or by a village elder. I saw two different ones: to accept or to refuse circumcision.

I saw a potentially liberated, revolutionary woman in charge of her own body. She saw an ancestor willing and eager to carry on her people’s traditions. I mentioned I had physician friends in Sudan who were advocating abolishing the practice and that she could find ways to avoid having the procedure done.

“Doctor, that is not my fight. We need your immunizations, food, and education. We do not need your traditions. But, I would like your help to get a circumcision. Other tribes’ mark with tattoos, piercings, or cuttings. Our mark is circumcision. It defines us as women of our tribe. The only reason we do not circumcise with anesthetic and clean blades is because we cannot afford them. Do not ask me to rebel against my people. I would have no home.”

I hesitated. “If I were to give you the anesthetic, a clean blade, antibiotics, bandages, and suture, could your village elder use them?”

“If you will not perform my circumcision then I would appreciate these things,” Beatrice answered.

I reasoned that giving her these things still left her the option of refusing circumcision. But as I gathered the sterile blade, topical anesthetic, suture, and bandage, and wrote the prescription for antibiotics, I couldn’t completely escape the sense that I had betrayed her and myself. I tried again to convince myself that I had washed my hands of her blood.

As Beatrice left the exam room, I knew that I had made the right decision. I did what I could to stop her, and when I couldn’t, I fulfilled my duty to help her.

2003 John Conley Ethics Essay Contest for Medical Students

You have two patients: a mother and her adult daughter. The mother has begun to show signs of early Huntington disease (HD). A test for the genetic mutation causing HD confirms your clinical suspicion. You have counseled the mother that her daughter’s risk of carrying the genetic mutation is 50%, but the mother has refused to discuss the issue with her daughter. She has also forbidden you to do so because she doesn’t want her daughter to be burdened with the knowledge that she might get HD. The daughter has told you recently that she is thinking of starting a family. She knows nothing about the family history of HD because her mother is the only source of information. The HD mutation is autosomal dominant and 100% penetrant. What do you do? What are your obligations to your two patients? What ethical considerations should be taken into account?

Entries must be postmarked by February 1, 2003, and sent to Conley Essay Contest, c/o MSJAMA, 515 N State St, Chicago, IL 60610. The author(s) of the best essay(s) will be awarded $5000 or a portion thereof. More information about the contest is available online at www.msjama.org.

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1135