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RESEARCH ARTICLE

Promoting genital autonomy by exploring commonalities between male, female, intersex, and cosmetic female genital cutting

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All forms of genital cutting – female genital cutting (FGC), intersex genital cutting, male genital cutting (MGC), and even cosmetic forms of FGC – are performed in a belief that they will improve the subject’s life. Genital autonomy is a unified principle that children should be protected from genital cutting that is not medically necessary. Safeguarding genital autonomy encompasses helping societies and individuals to explore wounds common across different forms of genital cutting regarding gender, power, the quest for cultural belonging, and social and sexual control. A desire to prevent alternative sexualities helps explain the origins of MGC’s medicalization starting in the nineteenth century, as well as the roots of the failed attempt to similarly medicalize FGC. The child with ‘ambiguous’ genitalia brings us face to face with the failure of the attempted alignment of sex and gender. Medical ethics, law, and human rights suggest a path forward toward genital autonomy.

Keywords: male circumcision; female genital cutting; intersex genital cutting; genital autonomy; human rights

All forms of genital cutting – female genital cutting (FGC), intersex genital cutting (IGC), male genital cutting (MGC), and even cosmetic forms of FGC (CFG) – are performed in a belief that they will improve the subject’s life. Genital autonomy is a unified principle that children should be protected from genital cutting that is not medically necessary. Safeguarding genital autonomy encompasses helping societies and individuals to explore wounds common across different forms of genital cutting regarding gender, power, the quest for cultural belonging, and social and sexual control.

A desire to prevent alternative sexualities helps explain the origins of MGC’s medicalization starting in the nineteenth century, as well as the roots of the failed attempt to similarly medicalize FGC. Ritual circumcision – male or female – is a public political statement by the compliant parents of sexual and social alignment and of submission to power. The cost of nonconformity is seen as too high and so the decision is carved in the body of the necessarily nonconsenting child. Genital cutting’s transformation power may promise to turn a child into an adult, a person of indeterminate sex into an unequivocal girl, or even a nonvirgin back into a virgin.

The child with ‘ambiguous’ genitalia brings us face to face with the failure of the attempted alignment of sex and gender. If contradictory responses to nonconsensual genital surgeries on female and male minors respectively reveal inconsistencies, the same can be said when comparing FGC and CFG. CFG is often performed in the

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developed world to conform oneself with conventional, heterosexuality based norms regarding body appearance, and is driven by a medicalized model of women's sexuality.

Medical ethics, law, and human rights suggest a path forward toward genital autonomy insofar as they protect groups that we are less inclined to safeguard. Applying these tools skillfully can assist us in making sense of what we see when we dare to glimpse into that awful darkness that reflects our own culture's strange obsessions, thereby helping us to find commonalities between different forms of genital cutting and different cultural wounds that help perpetuate genital cutting practices.

Introduction: genital autonomy defined and advocated

Genital cutting, in whatever form it may come – FGC, IGC, MGC, or even CFGC performed on adults – is performed in the belief that the procedure – no matter how physically injurious – will in some way improve the subject's life. Genital autonomy may be defined as the unified principle that all children should be protected from genital cutting that is not truly medically necessary.

Regrettably, humanity, for all our technological achievement and advancement in individual rights, may only be a short evolutionary step away from superstition, fear, and prejudice. Accordingly, genital cutting often arises as a by-product of an individual's or a society's attempt to resolve needs relating to one or more of gender, power, the quest for cultural belonging, and social and sexual control including control of alternative sexualities. Work to advance genital autonomy often encompasses helping societies and individuals to explore wounds around these issues that are common to the different forms of genital cutting.

While the terminology is of relatively recent provenance, the concept of unifying the separate movements and discussions relating to FGC (potentially including CFGC), MGC, and IGC has been around for decades. Hanny Lightfoot-Klein issued an early plea for genital autonomy, inserting a passionate chapter on male circumcision into her groundbreaking 1989 book on FGC, *Prisoners of Ritual* (Lightfoot-Klein 1989, 183–192). A decade later, Lenore T. Szuchman and Frank Muscarella traced connections between FGC, MGC, and IGC:

Sexual pleasure is limited physically by genital mutilation. In our culture, there is general agreement that the genital cutting performed on girls in some African cultures constitutes a gross violation of the individual's right to sexual fulfillment. Some have argued that a similar violation and consequent abrogation of the individual's right to sexual fulfillment occurs routinely in the United States in the 'corrective' genital surgery performed on intersexuals and in the circumcision of male infants. (Szuchman and Muscarella 2000, xii–xiii)

Szuchman and Muscarella included in the same book an arguably even more potent endorsement of genital autonomy, an integrated article by four expert authors titled 'Genital Surgery on Children Below the Age of Consent', addressing all three principal aspects of genital autonomy: FGC, MGC, and IGC (Lightfoot-Klein et al. 2000, 440–479).

MGC and FGC: querying gender-based terminology

Consideration of two of the three primary forms of genital autonomy – FGC and MGC – has been shaped by the gender-based formulation of the debate. Szasz has noted that:

[w]e call the removal of the foreskin of the male newborn ‘routine neonatal circumcision’, and the removal of parts of the female genitalia ‘female genital mutilation’. Language thus prejudges the legitimacy (or illegitimacy) of the practice. (Szasz 1996, 143)

The very distinction between MGC and FGC is artificial. We do not have separate terminology for assault of males and assault of females, nor for male murder and female murder. Isabelle Gunning notes commonalities between the two practices: ‘Both can be seen as unnecessary alterations of normal, healthy genitalia justified by questionable health benefits and bolstered by culturally, socially, or religiously defined notions of aesthetics and clearly delineated binary ideas of gender’ (Gunning 1999, 655–656).

The separate categories came about due to the different development in the West of MGC and FGC – though perhaps, as we shall see, the paths were not as different as one may think. Janice Boddy suggests a possible explanation for the widely disparate views: ‘intuitively, men and boys are not “natural” victims’ (Boddy 2007, 59). It follows that whereas women’s acquiescence in FGC is viewed as evidence of denial and repression, men’s silence about circumcision is viewed as evidence that MGC is harmless and/or of men’s bravery and machismo.

Those who have attempted to break the silence on the differential treatment of these two issues have not always found the road a smooth one. When the Canadian ethicist Margaret Somerville began speaking in opposition to circumcision of newborn males, she found herself denounced by feminists who 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 point out that the same ethical and legal principles applied to both. (Somerville 2000, 211)

Anthropologist Kirsten Bell received similar reactions when she started to trace commonalities between FGC and MGC (Bell 2005, 131).

In a study by Reed Riner (1989) of 144 preindustrial cultures, genital modification was performed in 23. These 23, Riner found, were distinguished from the other 121 cultures by a ‘particular combination of traits – patrilineal descent, patrilocal residence, polygamy, the presence of strong fraternal interest groups, internal warfare, male individuality, and control over women and children’. Of the 23, some cultures modified the genitals of both boys and girls, or boys but not girls, but not a single culture modified girls and not boys. ‘This suggests’, Riner comments, ‘that female genital modification is somehow dependent on the cultural presence of male genital modification, and that if we explain the latter we have, for the most part, explained the former’ (Riner 1989). Clearly a powerful process of association is at work: an association of two genital modifications that are habitually conceived of as radically different phenomena.

Intersex surgeries interject an illuminating third perspective, intriguingly – and troublingly – querying the boundary between the asserted dichotomy, raising potentially troubling questions that culture tries to quash through medicalized (though not truly medical) procedures. For those individuals born with genitalia that do not fit cultural desires or that raise discomfort, genital cutting is often the recommended course of action. Families are encouraged by the community at large to physically transform their child, even if (or perhaps because) conformity exacts serious physical, sexual, and psychological tolls on the individuals.

The root problem with our grasping the parallels between, on the one hand, FGC, and on the other hand, MGC or IGC, seems to be our inability to understand that, as Henrietta

Moore wryly puts it, ‘The West, it turns out, has culture just like everyone else’ (Moore 2007, 311). African women, or so the unconscious assumption all too often runs, are mired in culture; ‘we’ hold the truth (Boddy 2007, 57). Yet it is not only *other* cultures that may fall prey to gender and sexual stereotypes. And our failure to grasp this simple truth is precisely a blind spot that most persistently sticks in the throat of non-Western women.

It is understandable that Western observers have trouble objectively analysing the West’s own practice, male genital cutting. Throughout the world, as Richard Shweder has written, people recoil and say ‘yuck’ to other cultures’ body mutilation practices while justifying their own practices and saying ‘yuck’ to cultures that have *not* adopted their own particular customs (Shweder 2002, 222, 225).

Medicalization to the rescue?

One of the most powerful forces in what we might call the ‘yummifying’ of genital cutting has been the process of increased medicalization of our lives. With the historical development of the medical institution, and with the shift of the epistemological paradigm from religion to science, physicians greatly elevated their social status and assumed greatly enhanced power over the human body.

In the nineteenth century, at least portions of the medical community came to perceive a medical need to circumcise both boys and girls. The first known medicalized genital surgery occurred in 1822 in Berlin. No physician practicing at the end of the nineteenth century would have disagreed that masturbation, unless stopped at a young age, had all sorts of dire consequences, including blindness and insanity (Gollaher 2000). The doctors knew the obvious, that the foreskin enhanced male erotic response. Accordingly, doctors focused on demonizing the foreskin to further their campaign to control childhood sexual activity (see Darby 2005, 93). Doctors and society feared a danger of knowledge of masturbation spreading virally through boys’ schools as one boy initiated another into this intimate act, so that by preventing masturbation, circumcision would also stop at least one of the most fearsome alternative forms of sexuality, sexual intimacy between males (see Lyttelton 1887).

One early author conjured up horrific images of masturbation and other forms of alternative sexuality (sodomy) terrorizing patients, and then presents the salvation, circumcision:

Hand in hand with its boon companion, sodomy, it [masturbation] stalks through every [mental] ward, entangling its victims more hopelessly with each passing night... In all cases, taken as they come, circumcision is undoubtedly the physician’s closest friend and ally, offering as it does a certain means of alleviation and pronounced benefit, granting as it does immunity from after-reproach. (Spratling 1895, 442–443)

This medicalization of children’s sexuality seemingly struck a chord with parents by providing them with an explanation of the origin of their children’s undesirable behaviors. Doctors promoted circumcision as a general means of social and sexual control capable of promoting improved health, enhanced work capabilities, longevity, and protection from tantrums and diseases. Genital surgeries gave parents a tool to control their children’s sexuality and gave doctors a chance to emphasize their authority over children and women’s bodies (Abd el Salam 2003).

It is important to remember, as mentioned earlier, that this antisex advocacy was not at all limited to males. At the birth of the medicalization of MGC, many doctors also forcefully advocated for the parallel use of FGC, based on more or less identical reasons – ostensible prevention of masturbation and other alternative sexualities, including homosexuality, ostensible cure of numerous diseases, and – in what was at the time partly synonymous – promotion of moral rectitude.

A 14-year-old ‘idiotic’ patient was said to have been cured of her ‘excessive masturbation and nymphomania’ after being ‘declitorized’ (Shorter 1992, 82). Early advocates of genital cutting wrote about MGC and FGC in the same breath, as in Belle Eskridge’s 1918 article in the *Texas State Journal of Medicine*, ‘Why Not Circumcise the Girl as Well as the Boy?’ (Eskridge 1918) or Kistler’s article in JAMA in 1910, ‘Rapid Bloodless Circumcision of Male and Female and Its Technic’. Kistler writes, ‘Many females need circumcision, and the operation is more easily performed than in the male’ (Kistler 1910, 1782). Although several European authorities had recommended clitoridectomy to treat nymphomania (Shorter 1992, 82), they had few English followers. One was Samuel Ashwell, who wrote in 1845 that ‘an enlarged clitoris’ was sometimes marked ‘by exquisite sensibility of its mucous membrane’, which often ‘gives rise to sexual passion and subdues every feeling of modesty’. The result was headaches, attacks of hysteria, and loss of mental discipline, and Ashwell recommended extirpation of the organ in these instances (Ashwell 1845, 708)

Darby stresses the similarity in the historical views of the two practices, noting that we may have come very close to a present-day United States in which both FGC and MGC are routinely practiced:

Comparisons between the male and female anatomies were central to the debate over clitoridectomy, but it was widely assumed that the foreskin and clitoris had similar a function [sic] and played the same vital role in masturbation.... Sander Gilman... comments that “circumcision and clitoridectomy were seen as analogous medical procedures”. It is remarkable how close the British medical profession came to endorsing clitoridectomy. (Darby 2005, 144)

Probably this fate was avoided only due to the fact that authorities tended to be less concerned about the distaff side as they supposedly pleased themselves at much lower frequency.

Medicalization can be understood as medicocultural disciplining of bodies whose appearance departs from social and cultural desires. Surgical normalization – whatever the letter may be preceding ‘GC’ – has been one method of reconfiguring such ‘deviant’ bodies (see, e.g., Karkazis 2008, 10). When such procedures become accepted, physicians can shift responsibility for making the decision from themselves to the parents. One conundrum posed by medicalization of genital cutting of infants is the requirement of informed consent for all medical procedures. It is questionable whether parents have the legal right to consent to surgery on their infants that is irreversible, fundamentally cosmetic, and often medically unnecessary (Lareau 2003, 130–131; see also Ford 2001; see also Svoboda 2012).

In recent decades, childbirth has been increasingly medicalized, and that process has helped reinforce the medicalization of MGC. Of course, the medicalization has continued into recent times with California legislators having passed into law Assembly Bill 768, which declares that male circumcision has ‘health and affiliative benefits’ and thereby purports to establish a parental right to circumcise. Medicalization of MGC is of course in full swing in Africa as an asserted protection against AIDS, with the enthusiastic

endorsement of the World Health Organization (WHO 2006), under what certain critics (see, e.g., Garenne 2006) consider an imperialistic impetus propelled by developed world dollars.

Medicalization does have at least some theoretical benefits, in that a hospital procedure carries reduced risks relative to a procedure by nonmedically trained practitioners. Nevertheless, a major concern raised against any form of harm-reducing medicalization is that cutting will – given the stamp of approval of the medical establishment – become entrenched, which will prevent its eventual eradication.

Again, the parallels with FGC are closer than some may believe. Medicalization of FGC in the United States ended more recently than is commonly realized, as FGC was recommended in US medical journals (Wollman 1973) and written about in *Cosmopolitan* magazine well into the 1970s (Isenberg and Elting 1976), thereby incidentally laying the groundwork for today's cosmetic FGC.

Roots of FGC, MGC, and IGC in quest for social control and sexual control

Genital cutting – whether it be FGC, MGC, IGC, or CFGC – often arises in response to issues partaking of one or more of gender, power, the desire to achieve cultural belonging, and social and sexual control including control of alternative sexualities.

Gender is one potent axis along which both FGC and MGC are commonly explained and justified. Numerous cultures, including the Dogon and Bambara of Mali, the Kono of Sierra Leone, and in Somalia, believe that the human body has soft female and hard male components, and that FGC removes the hard parts from the girls and MGC takes the soft parts from the boys to give both an unambiguous sex (Brain 1979, 87; Montagu 1995, 13; van der Kwaak 1992). Among the Kono, '[r]emoval of the external glans and hood is said to activate women's 'penis *within* the vagina' (Shweder 2009, 14). One Egyptian author notes:

As a young boy grows up and finally is admitted into the masculine society he has to shed his feminine properties. This is accomplished by the removal of the prepuce, the feminine portion of his original sexual state. The same is true with a young girl, who upon entering the feminine society is delivered from her masculine properties by having her clitoris or her clitoris and labia excised. Only thus circumcised can the girl claim to be fully a woman and thus capable of the sexual life. (Shaalan 1982)

Also evident here is a normative sexuality and hidden heterosexism, an attachment to mainstream sexual practices and an aversion to alternative sexualities. Pollack writes that male circumcision partakes of issues of identity, gender, and power, commenting, 'In every circumcising society, MGC functions to fulfill multiple unspoken social, political-tribal, and sexual needs' (Pollack 2011). MGC and FGC always entail a larger individual performing a harmful and hurtful procedure to a smaller individual. IGC also supplies a piece in the puzzle that society is evidently trying to solve relating to gender. Through IGC, difference is literally inscribed on the bodies of women and men whose 'natural' bodies are not sufficiently different for socially appropriate reproduction. Thus, all three forms of genital cutting are closely related to issues of power and domination.

Paige and Paige claim that male circumcision originally functioned as a vehicle for attempting to achieve by means of ritual, what could not be accomplished by means of political arrangement: that is, the defusing of possible competitive claims by male progeny for the same limited resources (Paige and Paige 1981, 166). In preindustrial societies, in

which survival was predicated on secure allegiance to clan and tribe, the father proved his loyalty to his tribe by subjecting his son's potential for procreation to the knife (Glick 2005, 18; Paige and Paige 1981, 151). Accordingly, circumcision was not a private ceremony or surgery but rather a social and political statement of alignment and loyalty. Pollack notes the nominally incidental outcome of 'a re-assertion and institutionalization of a power structure based on gender' (Pollack 2011). MGC represents a permanent, dramatic, bloody, public ritual of submission of the individual to the group, of the father to his 'fathers'. It represents a taming, a harnessing, done for the ostensible sake of the group's survival, but done without regard to effects on the individual or, indeed, the long-term effects on the group.

Genital cutting serves as a means of social and sexual control of children. One frequently cited justification for FGC is that it is a means to contain women's sexuality within socially approved bounds, focusing it on the social goals of marriage, fertility, and reproduction (Moore 2007, 321–322). Both FGC and MGC were intended to help incorporate boys and girls into adult societies of sexuality, reproduction, and family. Even where performed on infants and thus necessarily not a rite of passage for the infant himself, secular MGC doubtless may be motivated by an inchoate desire to formally induct them into the community and to help them along in life. Men are performers, initiators, and often the most ardent supporters of MGC, and women are performers, initiators, and often the most ardent supporters of FGC (Boddy 1982, 686–687). Interestingly, some of the leading advocates of CFGC are portraying it as a form of liberation demanded by women:

Women should be empowered by knowledge of the modern day advances in vaginal surgery, including rejuvenation techniques and cosmetic enhancement. Knowing what is available, if so desired, is itself a form of liberation. Males are not the motivating force behind these new techniques, as many proclaim. Women are the ones pushing for this liberation. (Apesos et al. 2008, vi)

Similar to MGC, FGC often is practiced to facilitate social control. Elena Jirovsky found that in Burkina Faso FGC occurs to channel female sexuality, not to negate it, but as a means of ensuring morally acceptable behavior (Jirovsky 2010, 84). Analogously, Bettina Shell-Duncan et al. recently determined that in Senegambia, 'being circumcised serves as a signal to other circumcised women that a girl or woman has been trained to respect the authority of her circumcised elders and is worthy of inclusion in their social network' (Shell-Duncan et al. 2011, 1275). Echoing Paige's work regarding MGC as a ritualized indication of loyalty and submission, Shell-Duncan et al. write that circumcision demonstrates a young woman's self-control over her sexuality and thus over her life:

in order to gain entry into women's networks, young women offer their deference or obedience to older women in the network, enhancing the leader's power and standing in the community... female circumcision serves as a signal that girls have been taught the art of subordination to their future husband, husband's brothers, and most importantly, to their mothers-in-law. (Shell-Duncan et al. 2011, 1281)

Along the same lines, El Guindi writes that FGC is meant to control sexuality only temporarily and for the purpose of social cohesion: '[female] circumcision is intended to control the sexual energy of a virgin until marriage. It is not considered a mechanism for the permanent reduction of the woman's sexuality' (El Guindi 2006, 37). Furthermore, striking parallels may be observed in the evolving rationales for both female and male

circumcision, rooted in a combination of restrictive sexual mores, religious rituals, and medical justifications (DeLaet 2009, 407).

As shown by the renowned anti-FGC activist, Hanny Lightfoot-Klein, parallel justifications are offered for FGC and MGC; these include claimed health benefits, absence of 'bad' genital odors, enhancement of physical beauty, greater attractiveness and acceptability of the sex organs, incorrect medical reasons, minimization of damage and pain, hygiene, preventing future problems, mistaken theories that it improves sex, or is universal, and its use as a rite of initiation into adulthood (Lightfoot-Klein 1997, 131–135). Others include looking like other children or like the child's parents, fear of promiscuity, and acceptance of altered genitalia as more attractive to the opposite sex (Hernlund and Shell-Duncan 2007, 18–19).

Intersex surgeries: responses to a social emergency or medicalized discipline?

By the middle of the twentieth century, intersex births had come to be labeled a medical and social emergency. Some medical authors addressing intersex surgeries explicitly label the situation as an emergency (Canty 1977; Lobe et al. 1987, 651; Farkas, Chertin, and Hadas-Halpren 2001, 2343), as did the American Academy of Pediatrics (AAP) (American Academy of Pediatrics 2000, 138), while others suggest that a 'lifetime of social tragedy can follow for the patient and family if the infant is not properly managed' (Donahoe, Crawford, and Hendren 1977, 1053). Ford adroitly observes, '[I]t is the parents and doctors of intersexed infants who are experiencing a medical emergency, not the intersexed infant' (Ford 2001, 477). Emphasizing thorough but swift clinical workups to determine the etiology, clinicians determine a sex for these infants, and surgeons then modify the infant's body, especially the genitals, to conform to the assigned sex (Karkazis 2008, 204, 207). Similarly, for tribal MGC, Paige and Paige (1981, 149) note that 'the boy who is circumcised is not himself the object of the ceremony, which is, in fact, conducted to impress others'.

With IGC, sexual and gender identity is also culturally created through genital cutting. Those outlaws who fail to conform their sex and gender to one of the two permitted options must be – or under the new more enlightened regime, may be – subjected to medicalized discipline. Gunning has noted the striking parallels between FGC and IGC:

While these [intersex] surgeries are performed on a smaller segment of the population, some of their functions are similar to those of the more common forms of [FGC]. In both cases, the dominant patriarchal culture constructs certain ideals based upon the notion that people are 'naturally' divided into only two distinct genders.... For those individuals born with genitalia that do not fit these rigidly defined categories, surgery or mutilation is the recommended course of action. Families are again encouraged by the community at large, including its most respected members, to physically transform their child, even if conformity exacts serious physical, sexual, and psychological tolls on the individuals.... In both cases, the parents decide that the cost of nonconformity for the child, for themselves, and for their families is too great, and decide for their children. (Gunning 1999, 663–664)

Gunning refers, of course, to the parents' decision to, as it were, carve their decision in their children's body. The motivation seems to be socio-cultural rather than medical, revealing less about *intersexuality* than about a social and medical *discomfort with intersexuality*. As one of the first books devoted to intersexuality tersely summarizes matters, 'In our society there are males and females and that is all. A person must live as one or the other' (Dewhurst and Gordon 1969, 304).

With apologies for the double pun, Cheryl Chase (now Bo Laurent) cuts to the chase:

The surgeries are incredibly sexist. They're based on the idea that men have sex; women are penetrated by men and have babies. What you produce [through intersex surgery] is somebody who has a body that is vaguely female, is infertile, doesn't menstruate, probably doesn't have any sexual function, might have genital pain, and has been lied to and shamed. That is supposed to be less painful than having a small dick? (Hegarty 2000, 124)

In a strange twist on the Dogon and Bambara, employing heterosexist norms, femaleness is defined as the absence of maleness (Hegarty 2000, 124–125).

Some surgeons performing surgery on intersex individuals have candidly acknowledged having made 'serious mistake[s]' and 'serious errors' (Gross and Meeker 1955, 315, 320). For well over a decade, Diamond and others have been eloquently and in closely reasoned papers calling for a moratorium on cosmetic sex assignment surgeries performed without the patient's consent (Diamond and Sigmundson 1997, 1047; Diamond 1999, 1025–1026). In recent years, these arguments have started to bear fruit as 'a slower and more judicious approach' has emerged to sex assignment surgery (Diamond and Beh 2008, 4). Nevertheless, 'despite the absence of any evidence linking cosmetic genital surgery with psychological well-being and medical benefit, these surgeries are still being performed' (Greenberg 2012, 21).

Shockingly, at least two studies have been published, the second a scant five years ago, announcing without a trace of ethical justification or apology studies done on infants to test clitoral sensitivity after intersex surgery (Gearhart, Burnett, and Owen 1995; Yang, Felsen, and Poppas 2007).

The FGC-MGC dichotomy in perspective

As we have seen, many of those who deplore operations on women as FGC have no objection to similar surgery on boys. In the traditional African societies that practice these forms of initiations, however, FGC has cultural significance similar to the meanings ascribed to MGC of boys (Beidelman 1997; Setel 1999, 27–50).

Activists opposed to FGC and/or to MGC can greatly enhance their effectiveness by collaborating together. Refusal to confront male circumcision actually makes the task of eradicating female circumcision more difficult. As we have seen, the same arguments used to buttress modification of male genitals in one part of the world support female genital modification in another part. Sami Aldeeb Abu-Sahlieh writes:

Female circumcision will never stop as long as male circumcision is going on. How do you expect to convince an African father to leave his daughter uncircumcised as long as you let him do it to his son? (Abu-Sahlieh 1994, 612)

Supporters of female circumcision in cultures that still practice it are quick to identify the double standard in the attitude of Western agencies that seek to eradicate female circumcision while tolerating, or even promoting, male circumcision. They point out that 'American parents circumcise their newborns so that the sons will look like the fathers... What, they ask, gives Americans the right to apply a different standard to African women?' (Gollaher 2000, 200)

The AAP opposes all forms of female circumcision as examples of genital mutilation that members are advised they should refuse to perform and should actively discourage (American Academy of Pediatrics Committee on Bioethics 1998). A brief egregious foray that attempted to condone clitoral 'pricks' (American Academy of Pediatrics Committee

on *Bioethics* 2010, 1092) was hastily reversed (Wyckoff 2010), highlighting the disparity. This position, short-lived though it was, sharply contrasts with the AAP's willingness to countenance the equivalent procedure on boys despite an admitted lack of medical justification, which one might reasonably conclude would forbid a medical organization from permitting the practice (American Academy of Pediatrics 1999). A new statement is reportedly imminent. One incisive authorial pair noted the instability of the double standard:

Feminists' insistence on the legal prohibition of symbolic genital nicks that remove no tissue may be more easily sustainable if male operations 'involving much more removal of tissue and no consent' are no longer permitted to proceed without protest. (Hernlund and Shell-Duncan 2007, 23–24)

Along similar lines, but bringing in CFGC as another point of comparison with MGC and FGC, and concluding that the three practices are treated inconsistently, Johnsdotter adds that a clitoral prick:

is far less invasive than what is done to male infants at Swedish hospitals during male circumcision and what is permitted on young women who go through genital plastic surgery. In a strictly medical sense, then there is no reasonable motive to forbid pricking of girls' genitalia while permitting male circumcision, genital plastic surgery, and genital piercing for aesthetic or erotic reasons. (Johnsdotter 2007, 126)

Despite the legal tolerance of MGC, no medical association that has issued a policy on MGC has found sufficient 'potential benefits' to justify the procedure. The British Medical Association (2006) points out that there is rarely any clinical need for circumcision, and that 'parental preference alone is not sufficient justification for performing a surgical procedure on a child'. Swedish (Guiborg 2012) and Dutch (van Dijk, Wigersma, and de Jong 2011) medical associations have recently issued calls for the cessation of the practice.

Given all the harms and risks, it can be hard to understand these practices' persistence, unless one appreciates the incredible transformational power that has been culturally attributed to genital cutting. One nineteenth-century physician's medical journal article stated in all seriousness that, 'Fully three-fourths of all male babies have abnormal prepuces' (Brown 1896–97, 300). While we might smile at the particular form this fantastic claim took, such a redefinition of normality is inherent in the process of genital cutting, and, indeed, is often one of its main goals. Genital cutting promises to turn a boy into a man, a girl into a woman, a person of indeterminate sex into an unequivocal girl (or, less often, an unequivocal boy), or even a nonvirgin back into a virgin. Regarding the final possibility, the Sudanese have an apparently unique twist on things in that virginity is literally recreatable through genital cutting:

[I]n Sudan, virgins are made, not born. The concept of virginity is an anomaly to the Western world.... Virginity in Sudan can be thought of as a social category, in the sense that the physiological manifestation can be socially controlled. Pharaonic circumcision [infibulation] actually transforms a girl or woman (whether or not she is a virgin by the Western definition) into a Sudanese virgin. (Hayes 1975, 622)

Lightfoot-Klein notes, 'Women have themselves resutured to pinhole size in order to be "like virgins once more"' (Lightfoot Klein 1989, 100). This surgery, as is common with all forms of genital cutting, is done for society's benefit, not for the good of the patient herself:

Q: So no one is really concerned over the physical or psychological trauma to which the child is subjected.

A: 'No, they are not worried about that at all. They do not even think about that. They think only of the virginity, not the child itself'. (Lightfoot-Klein 1989, 158)

Katrina Roen writes about intersex surgery using words that allude to fear of alternative sexualities while also applying to other forms of genital cutting:

The child's scars and lost genital tissue are the physical manifestation of the adults' fear of atypicality. Here, the adults are imagining a particular kind of embodied subject and surgically molding the child's body in the hope that the child will become that subject that the adults imagine. (Roen 2009, 22)

CFGC as an enforcer of social norms among consenting adults

Intersex surgery, like MGC and FGC, is primarily done for the benefit of the parents. One relatively recent study indicated, somewhat surprisingly, that parents would support genital surgery on their intersex infants 'even at the risk of reducing genital sensitivity'. (Dayner, Lee, and Houk 2004, 1762). Raising a child with a gender-atypical anatomy is still usually seen as untenable in North America. Surgery locates the problem in the child's genitals, not in social conceptualizations of what counts as sex (Karkazis 2008, 137). Intersex surgeries were undertaken to 'treat' parental and social anxiety about gender ambiguity, rather than to restore 'health' to their child (Murray 2009, 274). Nancy Ehrenreich and Mark Barr observe, 'Despite their good intentions, medical practitioners performing intersex surgeries, like their counterparts who perform female circumcisions, do not provide medically necessary treatment but rather enforce (perhaps unwittingly) a system of culturally specific gender norms'. The child with 'ambiguous' genitalia brings us face to face with the failure of our attempted alignment of sex and gender and our opposition of male and female (Ehrenreich and Barr 2005, 104–105).

A similar analysis could be applied to CFGC, which like other forms of genital cutting carries risks of complications (see, e.g., SteadyHealth 2011) and is performed without clear pathology and without an evidence base supporting its performance (Braun and Tiefer 2009). CFGC procedures include labia minora reduction, labia majora remodeling, pubic liposuction and lifts, and clitoral reduction, some of which resemble quite closely – in results, if not in the context of the surgeries – genital cutting procedures done 'traditionally' in African societies. Often the procedures are performed in a quest by the woman undergoing the knife to sculpt her body to match an 'ideal' set forth in pornography or other sources of normative sexuality (Crouch et al. 2011, 1508). One of the leading practitioners, David Matlock, M.D., in a chapter of his book titled *Centerfold Material*, relates, 'Many women arrive at my office with copies of *Playboy* and *Penthouse* in hand. They point to the models and tell me that they want their vaginas to look like those' (Matlock 2004, 64).

In a fascinating twist on the myths regarding gender dimorphism often driving FGC and MGC, labioplasty 'identifies as pathological a body that blurs the boundaries between distinctly "female" or distinctly "male" – "too long" labia render the vulva open to a male reading' (Braun and Tiefer 2009). One subject feels her inner labial lips are so long that '[i]t looked like I had a small penis dangling down' while another 'was so worried I thought I might not actually be fully female' (Braun and Tiefer 2009).

Observers have decried the evident manipulation 'of the media and public opinion to create markets for a *medicalised* view of sexual problems' (Braun and Tiefer 2009). The

medicalization of cosmetic FGC is facilitated through a vaguely defined condition created called ‘hypertrophy of the labia minora’ (Radman 1976), in close analogy with how false diagnoses of ‘phimosis’ and ‘redundant foreskin’ are used to justify neonatal male circumcision, despite the fact that the foreskin does not separate from the glans till the child is older and the foreskin naturally folds over itself. As with male circumcision, an American professional body has issued a somewhat ambivalent statement, on the one hand, admitting that the procedures ‘are not medically indicated’, while, on the other hand, not coming out and squarely recommending against them (American College of Obstetricians and Gynecologists 2007).

Paradoxically, the language and images describing such procedures is often an alternately sexualized and puritanical language, employing images of women using surgery to return to an ostensibly purer, freer, more natural form for their bodies. For example, one of the leading advertisers nationwide in the United States for labioplasty, Tri Valley Plastic Surgery in California, prominently features on its website stunningly suggestive, glossy photographs of beautiful women (Tri Valley Plastic Surgery 2012). Another website typically mixes the sexual with the ending promise of a return to a ‘presexual’ state:

Sometimes how a woman ‘perceives’ how she looks in the vaginal region can mean devastating effects on her life. It can threaten her self-esteem, reduce her sexual desire and excitement, ruin her love life, or cause vaginal discomfort. That’s why many women are now seeking cosmetic vaginal surgery to recreate sexual excitement, restore self-esteem and rejuvenate their love lives. [The surgery] returns the ruptured hymen to a pre-sexual state. (Cosmetic Surgery, P.A. 2012)

Numerous other observers have noted the apparent attempt of labia reduction ‘to return the vulva to a pre-pubescent state’ (e.g., Braun and Tiefer 2009), or so that one’s ‘fiancé says that sex with her is like being with a virgin’ (Matlock 2004, 48), both echoing the Sudanese view that infibulation can recapture virginity.

A number of observers point to the ironies of such widely varying valuations of related procedures. As if we did not already have enough double standards to deal with, African women perceive the legality of labioplasty as a ‘double standard’ in light of aggressive campaigns against any genital modifications, however minor, among women of African origin (Herlund and Shell-Duncan 2007, 19). Ford comments that ‘Beyond the geographic location of the surgery performed, there seems little functional difference between what is done by surgeons here and what they condemn elsewhere’ (Ford 2001, 485).

Sheldon and Wilkinson conclude, ‘there seems to be no relevant difference between all those practices prohibited together under the label of female genital mutilation and all those broadly tolerated as cosmetic surgery’ (Sheldon and Wilkinson 1998, 274). They find that FGC and CFGC are not necessarily fundamentally different but rather both practices appear to be situated on a continuum of body modification practices.

Medical ethics, law, and human rights: Can we back into protecting children?

Medical ethics, law, and human rights may offer a solution to the quest for unified genital autonomy, even if inadvertently so. Among the protections conferred by these three domains are safeguards against genital mutilations that are not medically justified.

Ethical concerns support genital autonomy. Denniston has shown that circumcision violates all nine ethical principles of the American Medical Association (Denniston 1996).² As Bell comments, from an ethical perspective, FGC and MGC look very similar,

as ‘each operation involves an unnecessary bodily violation that entails the removal of healthy tissue without the informed consent of the person involved’ (Bell 2005, 130). Even in the case of CFGC, which is of course performed on consenting adults, ethical issues may arise (Kelly and Foster 2012).

Regardless of whether FGC, MGC, or IGC is performed, the needs of the genitally modified infant are not addressed by the procedures. Rather, genital cutting treats the child as a means to society’s ends rather than an end in himself or herself, violating Kantian ethics.

The instabilities between the different practices are clear. FGC is strongly disfavored worldwide with numerous national laws prohibiting the practice. IGC is falling into disfavor but is still legally and medically tolerated, with some limitations. Sweden and South Africa have regulated MGC, though these countries’ laws have not substantially curtailed neonatal circumcision. Recently, a German court drew international attention for its decision that infant circumcision – either performed on a religious basis or otherwise – constitutes an assault that violated the child’s rights. In response, a resolution was passed by one house of the German legislature. Otherwise, the practice is legal worldwide. The law in the United Kingdom, the United States, and Australia forbids CFGC (see, e.g., Crouch et al. 2011, 1509–1510; see, e.g., Berer 2010, 107, 108), yet the law is never applied to them (see, e.g., Kelly and Foster 2012, 391). Johnsdotter and Essen ask:

How can it be that extensive genital modifications, including reduction of labial and clitoral tissue, are considered acceptable and perfectly legal in many European countries, while those same societies have legislation making female genital cutting illegal, and the World Health Organization bans even the ‘pricking’ of the female genitals? (Johnsdotter and Essen 2010, 29)

With regard to both IGC and MGC, the legal world is starting to catch up with activists and changing societal perceptions. In 1999, the Constitutional Court of Colombia significantly restricted parents’ and doctors’ abilities to perform genital cutting on intersexed children, forcing the child’s best interests to be prioritized over parental fears and social concerns. In *Boldt v. Boldt*, the Oregon custody case filed in 2004, which quickly became the most famous MGC-related legal case ever, a recently converted Jewish father had been seeking the circumcision of his son Misha against the wishes of the boy’s mother. The Oregon Supreme Court returned the case to the trial court for further proceedings including a determination of the boy’s wishes in the matter. At the remand hearing, held five years later in April 2009, the then 14-year-old boy testified privately to the judge that he did not want to be circumcised, testimony that the judge accepted on the record.

Numerous authors have critiqued the gender-based double standard in legal and human rights responses to MGC and FGC (see, e.g., DeLaet 2009, 423). Hellsten has argued:

male genital mutilation should not be considered in isolation from... female genital mutilation. From a human rights perspective, both male and female genital mutilation, *particularly* when performed on infants or defenceless small children... can be clearly condemned as a violation of children’s rights. (Hellsten 2004, 248–249)

And the whole reason intersex exists as a category is because these bodies violate *cultural* rules about gender.

Although MGC is currently illegal under existing laws and human rights treaties, Western-biased cultural blindness – the flip side of cultural relativism – has prevented

widespread official acknowledgment of this (Smith 1998). Cultural relativism is a nominally egalitarian doctrine, like equal protection and genital autonomy, calling on us to treat familiar and unfamiliar cultures with equal consideration and acceptance, yet somehow our impulses lead us to preferentially apply it to certain groups and not so rigidly to others (Ehrenreich and Barr 2005).

El Guindi notes that the feminist ‘agenda is narrowly focused on women in Africa and the Middle East, who can be presented as inferior, less advanced, or more oppressed than Western women’ and who ostensibly ‘must be saved by Western missionaries and feminists’ (El Guindi 2006, 42). Claire Robertson deftly observes that all too often Westerners find themselves operating from a ‘smug consensus that considers the United States to be an enlightened place that has long abandoned “terrible, cruel” practices, unlike [African] countries’ (Robertson 2002, 79).

As Diana Tietjens Meyers sums up matters, ‘The misconception that most incenses non-Western women is the “othering” of the very idea of culture – that is, the supposition that culture itself is a non-Western phenomenon and that Westerners are not themselves enculturated’ (Meyers 2000, 474). Along similar lines, Claire Robertson decries the:

American assumption of a superior U.S. civilization and African barbarity. It is also the pervasiveness of these assumptions that explains a set of U.S. laws that criminalizes genital operations done by Africans or for Africans but not those done by North Americans, even if the results are the same or similar. (Robertson 2002, 77)

Ehrenreich makes a similar point regarding IGC. ‘The Western medical science upon which the “need” for such [intersex] surgeries is based is not objective, neutral, or universally true but rather reflects patriarchal and heteronormative cultural influences’ (Ehrenreich and Barr 2005, 77).

Two commentators have argued that given the American law against FGC, MGC must also be illegal under the US constitutional principle of equal protection (Povenmire 1998; Bond 1999).

Kirsten Bell contends that the international scrutiny of FGC ‘must be accompanied by a similar willingness to scrutinize male circumcision and recognition that perceptions of one are fundamentally implicated in understandings of the other’. (Bell 2005, 140). A similar argument is put forth by R. Charli Carpenter, who criticizes the double standard inherent in the United Nations’ approach to ‘harmful traditional practices’, which focuses exclusively on women and girls and ignores ‘the most obvious one of all – the genital mutilation of infant boys, euphemistically known as... circumcision’ (Carpenter 2004, 309). Jacqueline Smith (1998) asserts that the relative degrees of harm arising from FGC and MGC are irrelevant, and that circumcision of male minors is as much a human rights violation as any form of FGC. ‘By condemning one practice and not the other’, she writes, ‘another basic human right, namely the right to freedom from discrimination, is at stake. Regardless of whether a child is a boy or a girl, neither should be subject to a harmful traditional practice’ (Smith 1998, 498).

While the United Nations has already endorsed in official documents the principle that MGC qualifies as a human rights violation under certain circumstances (United Nations 1994a, 1994b), it is only in the current millennium that male circumcision has been raised at the United Nations as a general human rights issue (Svoboda 2002), and to date no serious discussion of the topic has occurred, let alone any action (Svoboda 2004).

As with the inadvertent use of the Voting Rights Act to support women's suffrage, at first equal protection of males from MGC may arise as an accidental yet necessary result of our structure of human rights and legal doctrines. In short, we may back into conferring legal and human rights protections on males, but the rights will apply nevertheless.

Conclusion

We must remember, as Dreger reminds us (Dreger 1999, 18), that *every* gender assignment is necessarily preliminary, whether the child being assigned a gender is intersexed or nonintersexed. We need more enlightened doctors and citizens who say, as one did, 'If the [genetically XY] child grows up, and she's happy being a girl, we can do the [vaginal] surgery then. The difference is she is a part of the decision' (Karkazis 2008, 161). Humility helps, and also, as Vicki Kirby trenchantly wrote a full quarter-century ago, instead of the self-congratulatory and clichéd lamentations about third world clitoridectomy, 'we should dare to glimpse into that awful darkness which "reflects" our own culture's strange obsessions' (Kirby 1987, 52).

Such an objective approach may help us to expunge any potential taint of colonialism or favoritism toward the developed world that may arise from differential interpretations of various incarnations of genital cutting. This framework can facilitate finding commonalities between different forms of genital cutting and the different cultural wounds that can help perpetuate genital cutting practices.

Notes

1. An earlier and substantially different version of this article was presented on 1 September 2011 at a conference entitled 'Law, Human Rights, and Non-Therapeutic Interventions on Children' held at the University of Keele, UK.
2. Denniston addressed the then applicable seven AMA principles, but his analysis can be applied to all nine current AMA principles.

Notes on contributor

J. Steven Svoboda founded Attorneys for the Rights of the Child (ARC) in 1997. He has written on issues relating to genital autonomy in the *Journal of Medical Ethics*, *Journal of the Royal Society of Medicine*, *Medical Anthropology Quarterly*, all eight Springer/Kluwer circumcision symposium proceedings volumes and has presented the only known document ever accepted by the United Nations focusing on male circumcision.

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