Female genital mutilation: whose problem, whose solution?

Tackle "cosmetic" genital surgery in rich countries before criticising traditional practices elsewhere

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In this week's *BMJ*, Elmusharaf and colleagues present a study of the agreement between self reports of female genital mutilation and the findings of clinical examination in a cohort of girls and another of women.[1] They report that girls and women were inaccurate in describing what had been done to them, and that the actual mutilations did not readily fit into the World Health Organization's classification system. These findings have implications for research and, more broadly, for tackling the problem of female genital mutilation worldwide. They suggest that we need to re-examine our current conceptualisation of female genital mutilation with a view to defining a valid and reliable definition and classification system.

The literature on female genital mutilation is long on polemic and short on data. Some writers make unsupported claims of physical and psychological adverse effects, something that hardly makes their case more credible among the very people who need to be convinced in the cultures which practise genital mutilation. Recent evidence from a large, well conducted study by WHO confirms the association between female genital mutilation and obstetric outcome.[2] However, the associations are of modest strength: for women with WHO type III mutilations (the most severe) there was a relative risk of 1.3 for both caesarean section and infant resuscitation, and 1.6 for stillbirth or early neonatal death, and there was no increased risk for the 32% of women who had WHO type I mutilation. These findings place female genital mutilation somewhere behind maternal smoking as a risk factor in pregnancy.

But to attack female genital mutilation on the grounds of the associated risks implies that it is an unacceptable practice because it is medically dangerous. There is a risky corollary to this: if all female genital mutilation could be made as safe as WHO type I, would it then be all right?

European and American writers often assume that female genital mutilation is forced on unwilling young girls. This is at odds with the high social value placed on it in societies that practise it.[3] As a symbol of entry into adulthood and acceptance into society as a woman or man, genital mutilation in both sexes may have pivotal cultural significance. The young Pokot woman in the photograph was pictured on the occasion of her proud ceremonial walk around the village, marking the end of her period of convalescence after the ceremony and her first appearance as an adult. It reminds us that, if we are to change the practice of genital mutilation, we may be unwise to attack the underlying cultural significance and should concentrate on the form of the initiation ritual. There are encouraging signs that the cultures which practise female genital mutilation are responding to the concerns about the health consequences while trying to maintain their cultural values.[4 5]

In Pokot society as in many others, genital mutilation marks entry into adulthood

The high moral tone with which those in richer countries criticise female genital mutilation would be more credible if we in the rich North had not practised it and did not continue to practise it. We have conveniently forgotten that female "circumcision" was practised by the European and American medical professions in the 19th century as a cure for a wide variety of conditions including insomnia, sterility, unhappy marriage, and psychological disorders.[6] It was advocated by no less a figure than the father of gynaecology, J Marion Sima.[7] Jonathan Hutchinson, then president of the Royal College of Surgeons, enthusiastically advocated circumcision and "other measures more radical than circumcision" to prevent the adverse mental effects of masturbation as "a true kindness to many patients of both sexes."[8] The last known medical female circumcision in the richer world took place in Kentucky in 1953, on a girl aged 12.[9] Our own sexually repressive use of female genital mutilation may be at the root of our misunderstanding of its role in other cultures.

The practice of female genital mutilation is on the increase nowhere in the world except in our so called developed societies. "Designer laser vaginoplasty" and "laser vaginal rejuvenation" are growth areas in plastic surgery, representing the latest chapter in the surgical victimisation of women in our culture. The procedures offered include vaginal tightening and vulval remodelling to make the vulva appear more childlike. In the words of one of the many clinics offering these services on the internet: "Many people have asked us for an

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example of the aesthetically pleasing vulva. We went to our patients for the answer and they said the playmates of Playboy."[10] In other words, women are being mutilated to fit male masturbation fantasies, in what Faith Wilding calls "the full-scale consumer spectacle of the cyborg porn babe."[11] This burgeoning industry is able to operate without the slightest attention being paid to it by medical researchers. There is not a single reference to laser vaginoplasty on PubMed.

The WHO definition of female genital mutilation is "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious, or other non-therapeutic reasons." It is Western medicine which, by a process of disease mongering,[12] is driving the advance of female genital mutilation by promoting the fear in women that what is natural biological variation is a defect, a problem requiring the knife.

Ronán M Conroy *senior lecturer*

(rconroy@rcsi.ie)

Department of Epidemiology, Royal College of Surgeons in Ireland, Dublin 2, Ireland

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Reform of investigation of deaths

A draft bill on the coroner system misses important chances

The UK government has recently published a draft bill for reform of the investigation of deaths in England and Wales by the coroner system.[1] A coroner is an independent judicial officer and must be a barrister, solicitor, or, currently, a medical practitioner of not less than five years' standing (the last qualification is abolished in the draft bill). This proposed legislation heralds many changes, several with implications for doctors (box). These are all sensible evolutionary changes that will lead to a more consistent, effective, and better managed service. There are several problems, however, that the draft bill does not tackle.

The draft bill fails to cover important recommendations made by a government review of death certification and investigation,[2] by the Shipman Inquiry (which followed the murder of more than 200 patients by general practitioner Harold Shipman),[3] and by the UK Home Office.[4] Moreover, it does not give detailed instructions on the categories of deaths that should be investigated. Section 1 of the bill simply requires a senior coroner to investigate if she or he suspects that a death was violent or unnatural, if the cause of death is unknown, or the death occurred in custody. The bill does not discuss the format of certificates for notifying death and for authorising cremation and does not take up a previous proposal for a unified system of certification for burials and cremation because this might delay funerals.[5]

Another proposal not followed through was to appoint medical examiners to conduct medical investigations of natural deaths, approve death certificates, and promote proper certification practice among doctors. The draft bill does provide, however, for enabling each coroner to buy in medical support, and for the creation of the new post of chief medical adviser to the chief coroner. The vision (of the government's review and Shipman Inquiry) of a coronial service that

Reform of investigation of deaths in England and Wales

The draft bill will lead to:
- Fewer coroners
- A greater proportion of full time coroners
- A chief coroner who reports to the lord chancellor, oversees training and performance of coroners, and hears appeals against their decisions
- A coronial advisory council to give advice to the chief coroner and lord chancellor on the operation and administration of the coroner system.

The draft bill also:
- Clarifies coroners' powers to retain human tissues and organs
- Gives coroners substantial new powers to enter and search premises, including powers to seize paper and electronic records
- Clarifies when a jury should be present at an inquest and reduces the numbers of jurors required
- Gives powers to the lord chancellor to make regulations about investigations and rules for inquests
- Creates the post of "coroner for treasure"
- Proposes a charter for bereaved people who come into contact with the coroner's system, setting out rights to information, participation, and appeal.

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