Resolution 5-I-16, “No Compromise on Anti-Female Genital Mutilation Policy,” sponsored by M. Zuhdi Jasser, MD (Arizona Delegation), was referred to the Board of Trustees. Resolution 5-I-16 asked:

1. That our American Medical Association reaffirm its policy against female genital mutilation (FGM).

2. That, due to the public debate in 2016 over whether the medical community sanctions a proposed “nicking procedure,” our AMA must further clarify its current position on FGM to explicitly state that our AMA condemns any and all ritual procedures including, but not limited to, “nicking” or “genital alteration” procedures done to the genitals of women and girls.

3. That our AMA, on behalf of the medical community, actively advocate against the practice of FGM in all its forms (including the recently proposed “nicking” and “alteration” procedures) and effectively add the voice of America’s physicians to the voices of many anti-FGM human rights activists and their organizations which advocate for the survivors and victims of FGM.

4. That our AMA partner in this public advocacy with reputable anti-FGM activists and survivors including, but not limited to, Jaha Dukureh of the Tahirih Justice Center, Waris Dirie of Desert Flower Foundation, Layla Hussein of the Maya Center and the Dahlia Project, and Nimco Ali of the Daughters of Eve or Safe Hands for Girls to name a few.

5. That our AMA educate its membership and the American public about the harm of FGM prominently through its website and provide resources about the ethics and medical harm of any and all forms of FGM.

Testimony heard during the reference committee hearing strongly favored the spirit of this resolution. Concerns were stated over the fourth resolve (asking the AMA to partner with specific advocacy groups and survivors of FGM); the author of the resolution agreed that it was not appropriate to state specific groups or people without proper vetting and thus agreed that the fourth resolve should be removed. The reference committee recommended that the remainder of the resolution be worded more strongly, adding specifically that additional policy be created to state that any physician who participates in FGM should be considered unethical. This change was debated on the floor of the House. In addition, questions were raised about what should be considered “mutilation” (cosmetic labial reconstruction and gender reassignment surgery were...
cited), and concerns were raised regarding the freedom to practice strongly held cultural traditions. Thus, this resolution was referred to the Board of Trustees. This report summarizes the AMA’s position on female genital mutilation (FGM) and compromise procedures, and provides recommendations in response to the resolution.

BACKGROUND

According to the World Health Organization, female genital mutilation (FGM) comprises “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons [1].” The WHO delineates the different methods of FGM into four distinct categories, which are widely accepted and cited:

Type 1: Often referred to as clitoridectomy, this is the partial or total removal of the clitoris, and in very rare cases, only the prepuce.

Type 2: Often referred to as excision, this is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type 3: Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris.

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

These procedures can cause early and late complications. Early complications include bleeding, infection and urinary retention [2,4], though it should be noted that bleeding and infection are risks associated with virtually any procedure. Late and severe complications include urinary complications, scarring, pain, infection, pelvic inflammatory disease, infertility, stillbirth stemming from obstructed labor, postpartum hemorrhage, sexual dysfunction, and death [2-4]. Emerging evidence also suggests that FGM can cause long-term harms to mental health and post-traumatic stress disorder [2,3,10].

Each year, approximately 3.3 million girls worldwide, including 513,000 U.S. women and girls, are at risk of undergoing the procedure [1]. Female genital mutilation is most commonly practiced in Africa, the Middle East, Asia, and among immigrant communities in the US [1]. The procedure is variously seen as a rite of passage, a necessary precursor to marriage, and a way to preserve virginity, femininity and hygiene. Women and girls undergo FGM in response to societal pressure to conform with peers and on the assumption that FGM prevents promiscuity [1,2]. No matter the origin, the practice is widely held to reflect deep-rooted inequality between the sexes and is recognized internationally as a gender-specific violation of human rights [11]. The U.S. government opposes FGM of any type, degree, severity, or motivation for performing it, and it is against the law to practice FGM in the United States [5].

“Nicking”

In 2016, the Journal of Medical Ethics published an article that proposed “nicking” as an alternative to FGM that can balance respect for cultural values and traditions with preventing harm. The authors argue that a “nick” on the external female genitalia causes little or no functional harm and should be permitted to avoid more extreme procedures. They state that any society that tolerates male circumcision ought to permit female procedures of comparable harm and policies or
campaigns opposing all types of female genital alteration are culturally insensitive. Accordingly, the authors hold that “nicking” is neither gender discrimination (since male circumcision is widely performed) nor a human rights violation [4].

It should be noted that the World Health Organization, UNICEF and the United Nations Population Fund jointly adopted the categorization above, where “nicking” would be considered a Type 4 form of FGM [6,8].

Nicking versus Medical Male Circumcision

Arguments for nicking compare male circumcision as a culturally respectful alternative to FGM [4]. However, this is a false comparison. Male circumcision, of infants, adolescents or adults, may similarly reflect deeply rooted tradition. Unlike FGM or nicking, medical male circumcision is not rooted in discriminatory ideologies and has health benefits. Since 2007, the World Health Organization and Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended male circumcision for protection against sexually transmitted infections. For instance, the inner foreskin is highly susceptible to HIV infection, and circumcision can reduce the risk of female-to-male sexual transmission of HIV by approximately 60 percent. The procedure does not affect the sex organ or deny a normal sexual life [1].

Despite evidence showing the health benefits of male circumcision, the practice is nonetheless becoming less common in the United States [7], for reasons that are not entirely clear.

CURRENT AMA POLICY

AMA first adopted policy strongly opposing FGM in 1994. In 2012, the House of Delegates amended that policy to address the responsibilities of physicians practicing in the US. In its present form, H-525.980, “Expansion of AMA Policy on Female Genital Mutilation,”

(1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States [12].

NICKING AND COMPROMISE SOLUTIONS

According to the most recent UNICEF data [8], the method of FGM where the female genitals were “cut with flesh removed” (as opposed to cut with no flesh removed or genitals sewn closed) was by far the most common practice among the 25 countries for which data are available. In no country except Eritrea was nicking the most prevalent form of FGM. It should be noted however, that ethnicity within a country also plays a role; in Eritrea, the vaginal openings of 100% and 96% of girls of Hedarib and Afar ethnicities, respectively, were sewn completely shut. Of the six
remaining ethnicities identified in this survey for Eritrea, two predominantly practiced nicking and four predominantly practice cutting with flesh removed [8].

There are no readily available data to suggest that permitting nicking would dissuade individuals or families from seeking other, more harmful forms of FGM, even if other forms are legally prohibited. Studying the prevalence of illegal procedures has its own challenges, but to endorse an ethically problematic practice without strong evidence of efficacy is not appropriate. Further, there is little evidence that a nick would satisfy the ritual purpose or physical alterations for which FGM is carried out in the first place. Bodily change is, in many cases, the purpose of the ritual [9]. Verification that the procedure has in fact been performed is expected, whether through functional change (time it takes to urinate), body aesthetics (genitals that are smooth and minimal are seen as more hygienic), or change in sexual satisfaction and drive (in the case of clitoridectomy) [9].

EFFORTS TO ADDRESS FGM

Many organizations worldwide are addressing the issues of FGM. Organizations such as Equality Now and No Peace without Justice promote physician knowledge about FGM worldwide, while others such as The Olmalaika Home create safe houses for girls at risk for FGM in affected countries [13-15].

In the US, it is a felony to perform ritual cutting of any kind on a girl younger than eighteen years of age [2]. In at least one state (Nevada), a person may be prosecuted for the removal of a child from that state for the purpose of having FGM performed on the child [2]. It should also be noted that FGM can be the basis for claiming asylum in the United States [2]. Physicians practicing in the US may encounter patients who have undergone FGM or who request FGM for themselves or a family member. To fulfill their responsibility to provide respectful, culturally sensitive care, as AMA policy provides, physicians must have appropriate medical knowledge and skills and further, must have appropriate language to discuss medical issues with such patients. If asked to perform a type of ritual cut, it is important for the physician, while refusing to do so, to understand that many family members who continue this practice believe that they are doing what is best for their daughters [2].

RECOMMENDATION

In light of the foregoing analysis, which leads to the conclusion that AMA policy in its present form prohibits the practice of “nicking,” the Board of Trustees recommends that Policy H-525.980, “Expansion of AMA Policy on Female Genital Mutilation,” be reaffirmed in lieu of Resolution 5-I-16 and the remainder of this report be filed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


