



Forced genital cutting in North America: Feminist theory and nursing considerations

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This article will examine forced nontherapeutic genital cutting (FNGC) through the lens of feminist theory and in relation to the concept of social justice in nursing. I will address the underlying assumptions of feminism and how they apply to the two currently legal forms of FNGC in North America: male infant circumcision and intersex infant/child genital cutting. Through a literature review and critical analysis of these practices, I will illustrate the challenges they present when considering the role of nurses in promoting social justice. If feminism asserts that bodily integrity, autonomy, and fundamental human rights are essential components of gender equality, it follows that these must be afforded to all genders without discrimination. Historically, there have been few feminists who have made this connection yet a growing and diverse movement of people is challenging the frameworks in which we consider genital cutting in our society. Nurses are positioned well to be at the forefront of this cause and have a clear ethical duty to advocate for the elimination of all forms of FNGC.

History of forced genital cutting in North America

The medicalized genital cutting of infants and children was first promoted in Canada and the United States during the mid and late 19th century. Doctors encouraged the genital cutting of both male and female children to prevent masturbation and various diseases like epilepsy and tuberculosis.¹ In 1875, the American Medical Association published an article by Lewis A. Sayre, who stated that the foreskin caused clubfoot, curvature of the spine, and paralysis of the bladder.² A medical bulletin published in 1890 announced that circumcision cured blindness, deafness, and dumbness.² By the 1890s, the Orificial Surgery Society advocated that any deviation from a “normal” clitoris required partial or full excision, while circumcision, cauterization, and blistering were recommended as a treatment for masturbation for both sexes in a classic pediatrics textbook.³

Both male and female genital cutting continued to be performed in the 20th century, with justifications ranging from a prophylactic for the disease of the day to misguided attempts to enhance sexual sensation. In an article written for *Playgirl* magazine in 1973, calling female circumcision “the kindest cut,” Kellison⁴ claims “an awesome 75% of women are hindered from feeling the full extent of sensations, due to a condition which is most commonly known as ‘hooded clitoris’” (p. 76). The irony of amputating erogenous tissue in order to increase sensation after a century of genital cutting being performed to reduce sensation is difficult to miss. Although the last medical endorsements for female circumcision were published in the 1950s, Blue Cross/Blue Shield insurance covered this procedure until 1977.⁵

In Canada, the trend for males began to change when the Canadian Paediatric Society⁶ published a policy statement on male infant circumcision in 1975, stating, “there is no medical indication for circumcision during the neonatal period” and describing neonatal circumcision as “a mutilative operation of questionable benefit” (pp. 1–2). Canadian provinces began removing male infant circumcision from medical coverage and the rates of its incidence began to fall dramatically.

Intersex genital surgeries on infants and children continued to be performed without question until the 1990s when a number of events took place that shifted public and medical opinion. Research was published showing that biological factors were responsible for human behaviors and personality characteristics and the idea that culture accounted for all the differences between men and women was called into question. Patient advocacy groups like the Intersex Society of North America (ISNA) were formed and challenged medical assumptions on childhood genital modification that had been held for decades. The tragic case of David Reimer was publicly discussed in 1997, which played a significant role in forcing a moratorium on infant gender assignment surgeries.⁷ David was born with male genitalia, but suffered catastrophic damage to his penis during nontherapeutic infant circumcision. Forced gender reassignment surgery was performed and he lived unhappily as a female until he was 15 years old. He spent the next 18 years sharing his story publicly in order to discourage what had been standard practice, finally ending his own life in 2004.⁸ In 1996 and 1997, FNGC of female minors was criminalized in the United States and Canada, respectively; however, the same explicit legal protection was not enacted for intersex children or male children.

The persistence of FNGC in North America

While many European and Scandinavian countries have shifted the debate toward the true crux of the issue, namely, human rights and equality, Canada and the United States have not moved in the same direction as a society, despite significant changes in the guidance given by medical authorities and the emergence of vocal human rights advocacy groups. I believe financial profits and the hegemony of circumcisionism are two of the major reasons why North Americans continue to cut the genitals of children without medical indication.

Medical position statements

Somerville⁹ states, “As medical knowledge about infant male circumcision and, therefore, its medical justification changed, the ethics changed” (p. 204). Routine infant male circumcision performed on a healthy infant is now considered a nontherapeutic and medically unnecessary intervention that is not justified by parental preference.¹⁰

Strong cautions have been issued by medical regulatory bodies, such as the College of Physicians and Surgeons of Saskatchewan,¹¹ which states, “In any dialogue you have with the patients about potential circumcision of newborn male infants, be sure that you accurately and effectively convey the message that this is not a recommended procedure” (p. 1). The College of Physicians and Surgeons of British Columbia¹⁰ notes, “Routine infant male circumcision is an unnecessary and irreversible procedure. This procedure should be delayed to a later date when the child can make his own informed decision” (pp. 1–2). The Committee on Medical Ethics¹² points out “parental preference alone is not sufficient justification for performing a surgical procedure on a child” (p. 261).

Despite this, the rate of nontherapeutic male infant circumcision performed is 6.7% in Canadian hospitals and 32.5% in American hospitals.^{13,14} Ritual female genital cutting practices have been forced underground in North America as a result of the ban; however, a review of legal records shows that there has never been a prosecution due to this practice in Canada and only one in the United States.^{15,16}

The use of surgery to alter the genitals of intersex infants and children has fallen out of favor since the 1990s, yet like male infant circumcision, the legality of proxy consent by parents has not yet been tested in the courts. This final step is the largest hurdle that must be overcome in order for all children to be equally protected. We may see cases in Canada as early as 2015, when males and intersex individuals who were victims of forced genital cutting reach the age of majority. They may consider holding the government responsible for gender discrimination in only banning FNGC for females when the Canadian Charter of Rights and Freedoms states that all Canadians are entitled to bodily integrity without discrimination.¹⁷ As Shelley Wright-Estevam¹⁸ states, “You shouldn’t have to be born female to be protected from genital cutting” (p. 1).

Financial considerations

When considering this subject through a feminist lens, one could also query whether there is a financial gain involved in the perpetuation of a social norm. In the case of nontherapeutic male infant circumcision, there is a significant monetary gain for physicians who perform the procedure. Dr Neil Pollock¹⁹ of Vancouver, British Columbia, claims to have performed over 30,000 circumcisions, which would result in a CAD\$13 million pay check based on his fees.

Life Technologies²⁰ lists one tiny vial containing approximately 500,000 neonatal foreskin fibroblasts for purchase at \$360. Dr Paul Tinari estimates that each male infant’s foreskin, which is surgically removed in a circumcision, is worth approximately \$100,000 between the surgery fee and the resale value, which occurs when the tissue is sold for medical research or use in beauty products.²¹ Nurses who choose to assist in nontherapeutic male infant circumcisions could consider that a portion of their salary originates in the fees garnered from the surgery and potential tissue sale.

The incidence of intersex infant/child genital cutting is far less than the rate of male infant circumcision in North America, with an estimate of 1–2 infants or children per 1000 live births being operated on to change the appearance and function of their genitals (p. 161).²² However, the financial gains of surgery and subsequent postoperative care also exist in these cases and must be examined critically when considering the accumulating body of scientific evidence demonstrating the physical and psychological harm that can result from such surgeries.²³

Circumcisionism

Wisdom²⁴ defines circumcisionism as the “hegemonic view in society that circumcision is a normative and acceptable practice” (p. 2). I believe that circumcisionism has existed in North America for the last century and is embedded within family tradition, medicine, language, religion, and law. As with other societies that cut the genitals of children, circumcisionism is rarely discussed without controversy. When FNGC is criticized, it is also an indirect critique on the way parents raise their children, how they practice their religious beliefs, and even on their perception of “normal.”²⁵ While feminists have not shied away from the criticism of FNGC when it comes to other societies forcing it on their girls, the lack of discussion of what is being done to children in our society begs the following question: how can feminists escape from circumcisionism?

Feminist theory: assumptions

In examining the evolution of feminism and its many facets and expressions, I identified several assumptions that are significant in considering the issue of FNGC. The first assumption of feminism with regard to this issue is that feminism is for women, and therefore, feminists would not take up a position regarding FNGC when performed on any gender other than female. Many feminists critique the genital surgeries that

are forced on 2 million women and young girls annually, yet few feminists speak out when it comes to the FNGC of men and boys, which affects 13.3 million annually.²⁴

Second, the assumption is made that genital cutting is a mutilation only when done to the female body and genital cutting performed on males or intersex individuals is not comparable. Female genital cutting “violates girls’ and women’s human rights, denying them their physical and mental integrity, their right to freedom from violence and discrimination and, in the most extreme cases, their lives” (p. 1).²⁶ Feminist theory assumes that female genital cutting is a human rights and women’s rights issue, while male and intersex genital cutting is assumed to be a medical issue. The dissonance demonstrated in privileging one gender or sex over all others is at odds with the goals of feminism, which seeks to ensure gender equality and justice.

Feminist theory, social justice, and nursing

While traditional metaparadigms of nursing have not included the concept of social justice, I argue that nurses must address social injustices as an essential component of an upstream approach to nursing, as discussed by Schim et al.²⁷ How can nurses hope to be anything other than reactive when considering the staggering number of human rights violations and inequities that directly impact health and have yet to be addressed? The heart of feminist theory considers inequities and injustices, making it a natural partner with social justice in nursing.

Like feminists, nurses must also reflect on their assumptions and consider whether they are contributing to hegemonies like circumcisionism or actively attempting to change them. While a small number of nurses may list themselves as conscientious objectors when it comes to assisting with the act of FNGC, this may not be enough when considering the extent of circumcisionism in our society. Research, reflection, and cooperation in respectful education and positive advocacy efforts are required to address any social injustice. Phillips²⁸ states, “Nurses must not compromise their client responsibilities for a fear of controversy” (p. 38). As nurses, we are bound to advocate for the rights of all of our patients without discrimination. After more than 100 years of myth and misinformation contributing to the creation of circumcisionism, it is time for nurses to work alongside other human rights champions toward equally protecting male, female, and intersex children from FNGC.

Conclusion

Using feminist theory, I have presented a social justice nursing perspective on FNGC. The underlying assumptions of feminism, which apply to male infant circumcision and intersex infant/child genital cutting, have been critiqued. I have compared the responsibility of feminists and nurses with regard to addressing the hegemony of circumcisionism. The need for nurses and feminists to act in consideration of their responsibility to uphold principles of justice for all has been discussed. Society has undergone changes as a result of updated medical guidance and human rights advocacy within the past 30 years, which have laid the groundwork for a challenge to circumcisionism. Although there have been few feminists or nurses who have worked toward an equal protection for all children from FNGC, the time for these groups to fulfill their social justice responsibilities in this area has arrived and cannot be ignored any longer.

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