The medicalisation of female genital mutilation

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The 'medicalisation' of female genital mutilation should be denounced on two counts. Firstly, it is usually anatomically more damaging and, secondly, it goes against the ethical basis of the medical profession.

The 'medicalisation' of female genital mutilation/cutting (FGM/C) refers to the act being performed by doctors or other members of the health profession. The phenomenon is neither new nor unknown. The medical and paramedical professions have traditionally practised acts of mutilation in numerous countries in East Africa, primarily Egypt, Sudan, Eritrea and Somalia. It is a more recent, emerging phenomenon in West Africa where an increasing number of members of the nursing profession, midwives and *matrones* (traditional midwives) – and also doctors or surgeons – in Côte d'Ivoire, Mali and the rest of the sub-region are involved. Clinics that practise FGM/C have been identified in Kenya and Guinea.

Such acts of FGM/C are usually paid for, sometimes at a high price, on the pretext of 'better quality' or for safety reasons. Even in Europe, a few practitioners have offered 'safe' forms of FGM/C and even 'minimal' cutting to comply with tradition.

This practice is of growing relevance in asylum procedures where medicalisation tends to be viewed by non-medical experts (such as asylum officials) as a minor procedure and therefore not to be considered as persecution (unlike 'more severe', traditionally performed FGM/C). However, our experience over 25 years of treating and managing female genital mutilation and carrying out surgical repairs has given us a detailed understanding of the reality and impact of 'medicalisation', and we have no hesitation in denouncing these practices.

Anatomically more damaging

We have carried out reconstructive surgery on women who have been subjected to FGM/C and been able to compare the consequences of so-called medicalised practices with cutting carried out by traditional practitioners.[1] The immediate and inevitable conclusion is that in the vast majority of cases, medicalisation is clearly an aggravating factor in mutilation.

Ritual cutting consists of cutting off a larger or smaller portion of the clitoral glans by a more or less clean cut that extends more or less towards the apex of the clitoral shaft. Traditional cutters are very well aware of how far they can go, particularly in terms of bleeding, and they understand that the death of young girls will neither serve their reputation nor help with recruiting new clients. As a result, the main nerve trunks are – paradoxically – avoided and thereby protected, as injuring them would also involve opening up blood vessels, resulting in an uncontrollable haemorrhage. The same applies to the *labia minora* and vulvar tissue, which are difficult to access on a terrified young girl.

However, the use of anaesthesia – whether local, locoregional or general – makes it possible to cut, unhindered, a body that is open and at rest. Worse, a doctor, surgeon or health-care professional knows how to prevent haemorrhage and is therefore much less constrained by the presence of major blood vessels – and can cut much more extensively, as we have observed. Moreover, the fact of being a surgeon or gynaecologist increases their ability to cut more, without risk, because of their greater knowledge of this part of the body. Medicalised cases performed by specialists have often been the ones that were most difficult to repair.

A breach of ethics

Medicine must not be used for harmful practices; furthermore, carrying out acts without a person's consent or against their

wishes is a crime. The medicalisation of FGM/C is an absolute breach of ethics that affects and tarnishes the entire health-care community. Historically, any other attitude has led to appalling practice, such as the experiments conducted during the Holocaust or assistance in prolonging torture sessions. The same applies to medical support for harmful practices such as FGM/C.

For the last 25 years, medicine has helped us understand the reality of FGM/C and its consequences. This new understanding must serve the needs of women. A doctor or carer who carries out an act of mutilation commits a crime against the women who trust them, against the spirit and ethics of medicine, and against society.

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1. We have data from over 250 cases of medicalised FGM/C (some carried out in France). In addition, interviews with traditional female cutters have enabled us to gain a clearer understanding of their practices, while surgery on 4,500 cases (of all forms of FGM/C) has allowed us to understand the physiopathology of mutilation.