Why was the U.S. ban on female genital mutilation ruled unconstitutional, and what does this have to do with male circumcision?

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Summary

There are now legally prohibited forms of medically unnecessary female genital cutting—including the so-called ritual nick—that are less severe than permitted forms of medically unnecessary male and intersex genital cutting. Attempts to discursively quarantine the male and female forms of cutting (MGC, FGC) from one another based on appeals to health outcomes, symbolic meanings, and religious versus cultural status have been undermined by a large body of recent scholarship. Recognizing that a zero-tolerance policy toward ritual FGC may lead to restrictions on ritual MGC, prominent defenders of the latter practice have begun to argue that what they regard as "minor" forms of ritual FGC should in fact be seen as morally permissible—even when non-consensual—and should be legally allowed in Western societies. In a striking development in late 2018, a federal judge ruled that the longstanding U.S. law prohibiting "female genital mutilation" (FGM) was unconstitutional on federalist grounds, while separately acknowledging the logical relevance of arguments concerning non-discrimination on the basis of sex or gender. In light of such developments, feminist scholars and advocates of children's rights now increasingly argue that efforts to protect girls from non-consensual FGC must be rooted in a sex and gender-neutral (that is, human) right to bodily integrity, if these efforts are to be successful in the long-run.

Key words: female genital mutilation, male circumcision, intersex genital cutting, medically unnecessary, United States

Why was the U.S. ban on female genital mutilation ruled unconstitutional, and what does this have to do with male circumcision?

Introduction[1]

In November of 2018, a U.S. federal judge ruled that the 1996 U.S. law prohibiting "female genital mutilation" (FGM) was unconstitutional, prompting expressions of disbelief and outrage across the political spectrum (3–5). How could it be unconstitutional for Congress to protect little girls from an act that is widely considered to be an especially grievous form of gender-based violence? Even more shocking to some, the federal government subsequently declined to defend its own anti-FGM law, requesting instead that the matter be dismissed (6). On September 13, 2019, this request was granted by a U.S. Court of Appeals (7). There is currently no national-level ban on FGM in the United States.

In contrast to many observers, I was not surprised by the federal ruling. Only a few weeks earlier I had delivered a lecture to the U.K. National Secular Society explaining why the U.S. anti-FGM law might have to be struck down—and why other Western countries could soon follow suit (8). Indeed, legal theorists have argued for decades that a collision course with the U.S. Constitution was set in 1996, the moment the law was passed (9–12). In this essay, I will lay out some of the main reasons for this view, taking into consideration more recent events and scholarship. I will then briefly highlight a new proposal for how non-consenting persons might better be protected from medically unnecessary genital cutting practices going forward.[2]

[1] This paper is expanded from an informal piece published initially at *The Conversation* website (1). Some sentences, primarily in the summary, have been adapted from a previously published lecture abstract (2).

[2] According to a recent international consensus statement, "an intervention to alter a bodily state is medically necessary when (a) the bodily state poses a serious, time-sensitive threat to the person's well-being, typically due to a functional impairment in an associated somatic process, and (b) the intervention, as performed without delay, is the least harmful feasible means of changing the bodily state to one that alleviates the threat" (13) (p. 18). Definition based on (14).

Background on the U.S. statute

Let us first consider the wording of the crime. According to the 1996 statute, 18 U.S. Code § 116, Female Genital Mutilation, "Whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years" shall be fined or imprisoned or both (15). The word "circumcises" in this context is confusing for two reasons. First, among most English speakers, the word is much more strongly associated with cutting of the penis—i.e., male circumcision—than with cutting of the vulva. And second, insofar as "female circumcision" is a recognized term, there is no stable or widely shared agreement about what it means (16–18). The Latin basis for "circumcision" is *circum* (around) + *caedere* (to cut), meaning to cut around. Applied to the penis, this is generally understood to refer to cutting around the penile shaft – proximal to the glans – as a way of partially or totally removing the penile prepuce/foreskin (Box 1) (19). Applied to the vulva, it might be taken to mean cutting around the external part of the clitoris as a way of partially or totally removing the clitoral prepuce (or "hood"), but that is not the only way the term is used.

Instead, in practice, "female circumcision" may refer to anything from scraping, pricking, or nicking the clitoral prepuce (Box 1) without removal of any genital tissue (an instance of FGM Type IV on the World Health Organization [WHO] typology) to removing some portion of the clitoral hood without cutting the (rest of the) clitoris (FGM WHO Type Ia) to removing the clitoral hood along with at least some part of the external clitoris (FGM WHO Type Ib) to forms of cutting that (also) affect the labia (FGM WHO Type II) (20). "Excises" is also undefined in the statute, although in common usage it typically denotes *removal* of tissue. And "infibulates" is arguably misused: among specialists, the term distinctly refers to narrowing (often severely) the vaginal opening by cutting and repositioning the labia to form a covering seal, with or without modification of the external

clitoris or clitoral hood (21). In other words, "infibulates the labia" or "infibulates the clitoris"—phrases implied by the definition of FGM in the statute—verge on the nonsensical.

Box 1. A brief overview of the human prepuce. Adapted from (22). Quotes from (23). The prepuce is a "common anatomical structure of the male and female external genitalia of all human and non-human primates." In humans, the penile and clitoral prepuces are identical in early fetal development and remain indistinguishable in some intersex individuals. The prepuce is an "integral, normal part of the external genitalia that forms the anatomical covering of the glans penis and clitoris," thereby internalizing each and "decreasing external irritation and contamination." In the case of the penile prepuce, an additional function is to protect the urinary opening from abrasion, as this runs through the penile, but not the clitoral glans. In both cases, the prepuce is "a specialized, junctional mucocutaneous tissue which marks the boundary between mucosa and skin … similar to the eyelids, labia minora, anus and lips." The "unique innervation of the prepuce establishes its function as an erogenous tissue."

Nevertheless, the statute is more notable for what it does *not* say. It does not say that an exception to fining or imprisonment shall be made for cutting of the vulva that is done to fulfill a perceived religious obligation. Nor does it say that an exception shall be made for "minor" cutting (cutting that does not affect the clitoris, say, or which does not remove any tissue or leave a visible mark). It does not say an exception shall be made for cutting performed under clinical conditions with sterile instruments by a skilled operator. Nor is there an exception for wounds that heal completely and do not frustrate any bodily functions. Rather, any cutting, no matter how slight, of any part of the vulva, for any reason, is forbidden before age 18.[3]

The sole exception is for medical necessity (see footnote 2). This is to allow, for example, certain obstetric procedures during childbirth, which must be "performed by a

[3] Strictly, this depends on how the word "circumcises" is glossed. If it includes forms of cutting that do not remove tissue, consistent with common usages of the term "female circumcision"—or its translated equivalent—in many Muslim communities (24), then "any cutting" is a reasonable interpretation. If it *only* refers to forms of cutting that remove tissue, then it plausibly becomes redundant with "excises," which counts against this more restricted interpretation. Also counting against the restricted interpretation is a recent ruling from Australia's highest court, which held that, for legal purposes, (a) the clitoral prepuce is part of the clitoris, and (b) any cutting of this tissue that is not medically necessary constitutes illegal mutilation, no matter how slight and irrespective of whether there is any lasting functional impairment or damage of any kind (22,25).

person licensed in the place of its performance as a medical practitioner." Absolutely no accommodation is made for a person's sincere religious beliefs or deep-rooted commitment to a longstanding cultural practice, no matter how venerable (to them) or ancient in origin. In fact, such accommodation is explicitly ruled out: "no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual" (15).

This creates a legal problem. The problem is not, as I will argue, that the law *should* make an exception for custom, culture, religion, or ritual. Presumptively, girls have both a moral and, in many societies, a legal right to bodily integrity, including with respect to their genitals, whatever the culture or religion of their parents. Especially when it comes to their most intimate sexual anatomy (their so-called "private parts"), it is almost universally understood—at least within a Western ethicolegal context—that any cutting that is not strictly medically necessary, no matter how minimal, should be their own choice to make when they are old enough to understand what is at stake (13).

The problem, rather, is that the law *already* makes an exception for custom, culture, religion, or ritual when it comes to medically unnecessary genital cutting of other children, just so long as they do not have a vulva. On the surface, at least, this looks like an unconstitutional form of sex-based discrimination, an interpretation to which I will return later on.

Sexual anatomies

There is more than one way not to have a vulva. This includes being born with a difference of sex development that leads to sexually ambiguous genitalia, neither fully masculinized nor feminized; or being born with male-typical genitalia (26–28). Some individuals with

ambiguous genitalia are subjected to highly invasive, yet medically unnecessary surgeries before they can give their own informed consent (29–34). Typically, the goal is to shape their genitals into something that more closely conforms to a stereotypically masculine or feminine appearance. These surgeries, which include "cosmetic" reductions of the cliteropenile organ (Figure 1), risk permanent nerve damage and loss of sexual sensation. They can also have detrimental consequences for an individual's body image and self-esteem (35). The implicit message heard by many people subjected to such surgeries, some of whom later identify as intersex, is that they had to be "fixed" before they could be fully loved and accepted (36–39).

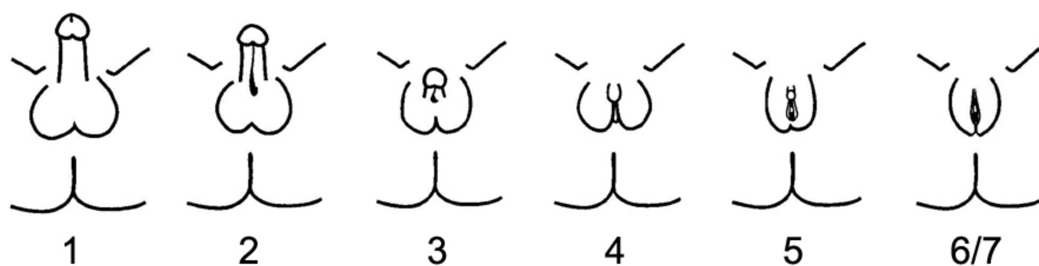

Figure 1. Differences of sex development resulting from androgen insensitivity, ranging from characteristically male genitalia (left) to characteristically female genitalia (right) (40). Some children are born with a clitoropenile organ that is neither determinately male (a penis) nor female (a clitoris). At what degree of feminization or masculinization of this organ should it be considered morally or legally permissible to cut a child's genitals when it is not medically necessary to do so (2)? This figure description is adapted from (41).

Likewise, individuals born with more stereotypically male genitalia (both boys/men and transgender women)[4] also face routine surgery on their healthy sexual anatomy before they can give their own informed consent. At least, they do in the United States, where ritual penile circumcision was "medicalized" in the late 1800s—partly in an effort to combat

[4] There is now growing recognition that some people born with penises may not identify as boys/men, such as transgender women and some genderqueer individuals (42–45) At the same time, "the potential harms of neonatal or early-childhood [penile] circumcision for trans women who elect a penile inversion surgery—as a part of gender-affirming care, for example—has yet to receive much attention … the preemptive removal of a large proportion of sensitive, elastic genital tissue from the penis that could otherwise have been used in the construction of a neovagina—i.e., the penile foreskin—is undoubtedly of relevance to the welfare interests of such women" (22). Please note that this footnote has been adapted from (41).

masturbation, among other dubious causes (46–48)—and where a majority of male-categorized persons continue to be circumcised at birth for non-religious reasons (this is a unique phenomenon among Western, developed nations) (49–51). In a typical male circumcision, a third or more of the penile skin system is removed (19), including the parts of the penis most sensitive to light touch (52–55). As such, a protective, erogenous sleeve of elastic tissue—the foreskin—is excised, often leaving a permanent scar (56).

In a small minority of cases, such circumcision is done for explicitly religious reasons, as in Orthodox Judaism (57). In the vast majority of cases, it is done for "merely cultural" reasons, sometimes bolstered by vague appeals to health or hygiene. In the last decade, task forces at the American Academy of Pediatrics (AAP) and the U.S. Centers for Disease Control (CDC) have lent their support to such appeals, by emphasizing potential health benefits associated with penile foreskin removal (58–63). But the main data on which they relied for this support concerned adult, voluntary circumcision and heterosexual HIV transmission in sub-Saharan Africa (64–71). These data cannot be straightforwardly applied to circumcision of babies in Western countries, where HIV infection is much rarer and where, moreover, it is not primarily transmitted among heterosexuals but among injecting drug users and men who have sex with men (72–74).

Accordingly, the relatively favorable stance toward penile circumcision taken by U.S. organizations in recent years has been effectively rejected by every comparable medical organization abroad, from the Canadian Paediatric Society (75) to the Royal Australasian College of Physicians (76) (see Box 2).[5]

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[5] I am reminded of something a Dutch colleague once said to me: "We in Europe keep surgery as a *last* resort for dealing with disease, especially when the same health benefits are possible without surgery, and even more so when the patient cannot consent. But in the U.S., your doctors *start* with a surgery on healthy boys, and say, given this surgery, what treatable infections that he could have avoided anyway will he have slightly less risk of getting?"

Box 2. International medical society statements on nonvoluntary neonatal male circumcision (NNMC). Adapted from (22); internal references omitted.

In 2015, the Canadian Paediatric Society concluded that the medical benefits and risks of NNMC were "closely balanced," while the Royal Dutch Medical Association maintained that there "is no convincing evidence that [NNMC] is useful or necessary in terms of prevention or hygiene." Meanwhile, the Royal Australasian College of Physicians, upon revisiting its 2010 policy in light of the AAP statement, affirmed that "the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand." Finally, the Danish Medical Association declared in 2016 that NNMC is "ethically unacceptable" on account of the known surgical risks, the lack of sufficient evidence of a "clear health benefit," and the permanency of the anatomical change. What these various positions suggest is that, insofar as NNMC does confer some kind or degree of health-related benefit, it is far from clear that this benefit offsets even the strictly health-related risks, let alone in a decisive manner. Thus, even the AAP, whose policy among comparable organizations is the most favorable toward circumcision, does not actually recommend NNMC on grounds of health.

As it happens, international criticism of the (now expired) American policy from 2012 was sufficiently censorious that it evoked three separate responses from the AAP task force (77–79), including one solo-authored by task force member Dr. Andrew Freedman. In his response, Freedman conceded various "difficulties" with the approach taken by the task force, including their failure to use any recognized method of accurately measuring, weighting, or balancing benefits or risks in their analysis (77).

Even more striking, however, Freedman frankly acknowledged the religio-cultural elephant in the room (80). "Most circumcisions," he wrote, "are done due to religious and cultural tradition." In the West, "although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of nonmedical reasons" (77) (p. 1). He went on to say: "There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision. Few parents when really questioned are doing it solely to lower the risk of urinary tract infections or ulcerative sexually transmitted infections" (77).

Indeed, as Freedman stated in a separate interview: "I circumcised [my son] myself on my parents' kitchen table on the eighth day of his life. But I did it for religious, not

medical reasons. I did it because I had 3,000 years of ancestors looking over my shoulder" (81).

Untenable legal distinctions

Both kinds of surgeries on children with genitals-that-are-not-clearly-vulvas pose a problem for anti-FGM laws. In some children with ambiguous genitalia, for instance, there is virtually no difference between a small penis (which is currently regarded as legal to cut) and a large clitoris (which is currently regarded as illegal to cut) (82). That is an untenable legal distinction. It is increasingly recognized that sex—let alone gender—is not a simple binary, and that female-typical or male-typical genitalia do not categorically map on to XX or XY chromosomes (see Figure 1) (83–85). These facts should put pressure on any law that, like the 1996 U.S. statute, *defines* a crime in terms of presumably binary, sex-specific body parts (86).

But one needn't appeal to intersex cases to see why sex-specific genital cutting laws cannot stand. Based on the reasoning of the federal judge who recently struck down the U.S. anti-FGM law, even routine, medically unnecessary penile circumcision—if it continues to be tolerated when non-consensual—may ultimately vitiate the constitutional basis for such laws.

According to the judge, Bernard Friedman, the anti-FGM law concerned activity that was *already illegal* at the state level. "As despicable as this practice may be," he wrote, "it is essentially a criminal assault" (5). Because Congress isn't allowed to regulate "local criminal activity" under the Constitution unless it substantially affects interstate commerce, in passing the 1996 law, it overstepped its bounds: "FGM is not part of a larger market and it has no demonstrated effect on interstate commerce. The commerce clause does not permit Congress to regulate a crime of this nature" (5).

In one sense, this is a reassuring verdict for those who wish to protect girls from this particular form of violence: just because the federal law was struck down, it did not thereby

become legally permissible to cut little girls' genitals for religious or cultural reasons. According to the judge, such cutting was already a crime, as it always had been. Simply put, cutting someone's genitals without (valid) consent is by definition an assault and battery—and if done to a minor, also child abuse—unless it is medically required surgery that cannot ethically be delayed until the person's own consent can be obtained (87–91).[6] Such assault is already illegal in all 50 states.

In other words, there is no need for special anti-FGM laws to prosecute those who perform medically unnecessary female genital cutting, or their accomplices, though at least 35 states do have such laws (96). Not only are such special laws unnecessary, however – and here is the rub – they may also be unconstitutional. As my colleague Sarah Johnsdotter and I argued in a recent publication:

> Virtually all Western constitutions hold that males and females, members of different racial or ethnic groups, and adherents to different religions, must be treated equally before the law. Under current zero-tolerance laws, female ritual nicking, which does not remove tissue and—contrary to common misconceptions—is practiced for explicitly religious reasons within some sects of Islam, is regarded as a criminal act even if done with pain control and sterile equipment by a medically trained provider. At the same time, non-consensual male circumcision, which removes roughly 1/3 to 1/2 of the motile skin system of the penis, [is treated as legal] whether or not it is practiced for explicitly religious reasons, and even if done without pain control in an unhygienic manner by a medically untrained provider [for example, among some Hasidic Jews]. Thus males and females, as well as Muslims and Jews … are not currently being treated equally before the law. (41)

Officially, Friedman stayed silent on this issue. But his ruling includes language which suggests he was aware of the general problem. Referring to an international treaty ratified by

[6] For arguments that so-called parental "proxy" consent (that is, permission) for medically unnecessary genital surgeries are not morally or legally valid, regardless of the child's sex or gender, see, e.g., these references: (92–95) Needless to say, a parent cannot "consent" to the assault and battery of their child.

the U.S. Senate in 1992, which states that every child has certain rights without discrimination as to race, sex, or religion, among other protected characteristics, Friedman wrote: “As laudable as the prohibition of a particular type of abuse of girls may be, it does not logically further the goal of protecting children on a nondiscriminatory basis” (5).

The same reasoning applies to the states. More than twenty years ago, Shea Lita Bond—later a General Attorney for the Social Security Administration—published an article in the *John Marshall Law Review* entitled, “State Laws Criminalizing Female Circumcision: a Violation of the Equal Protection Clause of the Fourteenth Amendment” (9). Highlighting potential double standards based on both sex and religion, Bond reasoned that courts would ultimately have to “strike down FGM statutes as unconstitutional,” and proposed that “state legislatures enact gender neutral, generally applicable circumcision laws which protect all children from unnecessary modification of their genitalia” (9) (p. 355).

To simplify somewhat: criminal assault is criminal assault. There can be no “female assault” or “male assault” under Western constitutional regimes (90). So, if medically unnecessary, non-consensual female genital cutting—specifically of the kind at issue in the federal case, to be discussed below—is criminal assault, then so must be male genital cutting (similarly qualified).

Against this view, it might argued that “FGM” is not a religious practice, and is also much more harmful than male circumcision, so perhaps a sex-specific law could be justified on those grounds. But such an argument cannot succeed (97–99). As indicated earlier, the WHO typology for FGM includes multiple different practices carried out by different groups for different reasons. Some of these practices are explicitly religious in nature while being markedly less severe than male circumcision (100–102).

A case in point

Consider the case that prompted the federal ruling. It concerned a small Muslim sect called the Dawoodi Bohra. The Bohras practice what they call "khatna" – an Arabic word for circumcision – on both girls and boys within their community (103).[7] Both forms of "circumcision" are justified by the Bohras on the basis of a religious text they follow called the *da'a'im al-Islam* (107). Both forms have been medicalized (that is, performed by a doctor with sterile equipment). And the form of cutting the Bohras do to their daughters is typically more superficial than what is done to their sons (96).

In the female case, "a pinch of skin" is typically cut or removed from the clitoral hood, often leaving no visible sign of alteration (107). In the male case, the entire penile foreskin is removed, leaving an unmistakably altered sexual organ. According to the ruling by Friedman discussed in the previous section, the less severe female procedure is already illegal in all 50 states—as a criminal assault. It might seem, then, that the more severe male procedure must also be a criminal assault. In fact, that has been a dominant view among legal scholars who have addressed the issue since 1984 (11,12,88,90,91,93–95,108). However, the male procedure continues to be *treated* as legal regardless of jurisdiction, including in its more dangerous forms.

What sort of forms do I mean? In New York City alone, according to city health officials, more than 3,000 babies per year are subjected to something called "metzizah b'peh" (109). This is an ancient, unhygienic form of male circumcision still practiced among some ultra-Orthodox Jews. In this form, the "mohel" (traditional circumciser) tears the immature

[7] This is a general pattern. Virtually every group that practices female genital cutting also practices male genital cutting (but not vice versa), often in parallel ceremonies serving similar social purposes. Thus, there are almost no societies that "single out" girls for cutting. By contrast, there are numerous societies that cut the genitals only of boys (104–106).

foreskin from the penile glans, typically without pain control, and then takes the baby's penis into his mouth to staunch the blood and supposedly "cleanse" the wound.

This can transmit the oral herpes virus. At least 11 baby boys have contracted the virus this way in recent years, leading to two known deaths and two cases of serious brain damage (110). Not only is this practice not treated as illegal—it isn't even regulated. Even an informal plan to require that a consent form be signed by parents was ultimately dropped by city officials (111). Instead, the NYC Health website currently recommends that parents "Talk to the mohel to make sure he rinses his mouth with mouthwash (Listerine™ Original Gold) for at least 30 seconds" before putting their newborn son's penis in his mouth (112). By contrast, the NYC Health website for female circumcision (FC) states: "While it may be a deeply rooted practice, it is not performed for medical reasons. It is done for religious, social, or cultural reasons [and puts] thousands of girls and young women [at] great risk for lifelong physical and psychological damage." It is also "illegal to perform FC in New York State." (113).

Health benefits?

There is at least one remaining point of contrast between male and female "circumcision" that might be used to justify a categorical difference in how the two procedures are treated in law. Even though neither procedure is (almost ever) medically necessary, only one of them has been statistically associated with certain health-related benefits—namely male circumcision, as noted earlier—and perhaps that is enough to ground their different legal status.

Let us see where such an argument would lead. First, if it were widely accepted, it would create a strong incentive for medically qualified supporters of female "circumcision" to conduct studies into, and generate evidence for, some statistical health benefit or another

(just as has happened with supporters of male circumcision) (46). As I will suggest in a moment, it is possible they would succeed. In fact, already today, in societies where female "circumcision" is common, alleged health benefits are regularly raised (114–122). According to the vice president of the Centre for Islamic Studies in Sri Lanka, for instance, "our religion requires [female circumcision] and it actually helps to keep the area clean and hygienic and prevents infections" (123). Or consider a common attitude among the women of Sierra Leone: "Why [would] any reasonable mother want to burden her daughter with excess clitoral and labial tissue that is unhygienic, unsightly, and interferes with sexual penetration ... especially if the same mother would choose circumcision to ensure healthy and aesthetically appealing genitalia for her son?" (124) (p. 17). If researchers from such societies had as much influence on the scientific literature (and on health global policy) as do circumcised males in the United States, perhaps there would be a comparable number of well-funded studies looking into health benefits for FGC. However, as medical historian Robert Darby notes:

> Official bodies working against FGC [such as the WHO] have condemned medicalization of the procedure and funded massive research programs into the harm of the surgery. The irony [is] that WHO also frames male circumcision as a public health issue—but from the opposite starting point. Instead of a research program to study the possible harms of circumcision, it funds research into the benefits and advantages of the operation. In neither case, however, is the research open-ended: in relation to women the search is for damage, in relation to men it is for benefit; and since the initial assumptions influence the outcomes, these results are duly found. (125) (p. 157).

Nevertheless, let us simply imagine that some form of FGC became reliably associated with statistical health benefits along the lines of what has been touted for MGC. We can take the example of medically unnecessary labiaplasty (FGM WHO Type IIa), which, when

performed on adult women, is considered a cosmetic practice in Western countries. As Alex Myers and I have noted elsewhere:

> Labiaplasty is similar to circumcision in that it removes genital tissue that is not necessary for sexual enjoyment but which nevertheless has certain [sensory and other] properties [that] many people value positively. It is also similar to circumcision in that the genital tissue it removes is often warm and moist and may trap bacteria, can become infected or even cancerous, may be injured or torn during sexual activity, and requires regular washing to maintain good hygiene. Removing the labia, therefore, likely does confer at least some statistical health benefits in that it reduces the surface area of genital tissue that is not essential for sexual function (in some narrow sense) but which may on occasion pose a problem of one kind or another for its owner. (22)

Of course, medically unnecessary labiaplasty is typically performed only with the informed consent of the affected individual (126). Suppose, however, that performing labiaplasty in infancy turned out to be "technically simpler, safer, and more cost effective—with a shorter healing time, and so on—than labiaplasty performed on a consenting adult" (22), similar to the claims that are often raised for male circumcision (127). Would these considerations be enough for *non*-consensual, *neonatal* labiaplasty to be treated as morally or legally permissible (128)? Or to put it a different way, would opponents of FGC make an exception for such a procedure? Presumably, they would not:

> First, they would argue that healthy tissue is valuable in-and-of-itself, so should be counted in the "harm" column simply by virtue of being damaged or removed. Second, they would point to non-surgical means of preventing or treating infections, and suggest that these should be favored over more invasive methods. And third, they would bring up the language of rights: a girl has a right to grow up with her genitals intact, they would say, and decide for herself at an age of understanding whether she would like to have parts of them cut into or cut off. (114)

It is difficult to see why the same arguments should not apply to MGC. As such, it seems that the "health benefits" strategy is not sufficient to justify the current asymmetries between FGC and MGC in terms of how they are treated in Western law and policy.

Rectifying asymmetries

Given such asymmetries, and the need for greater ethical and legal consistency, there are two main ways this situation can play out. Either "minor" forms of medically unnecessary, non-consensual FGC will have to be legally tolerated in the U.S., especially when performed for religious reasons (as in the case of the Dawoodi Bohra), or medically unnecessary, non-consensual male and intersex genital cutting will have to be restricted in some way. Such a restriction might include, for example, the introduction of a sex-neutral age of consent, as has been proposed by several authors (129–131).

Prominent supporters of ritual male circumcision are well aware of this dilemma. Rather than accepting an age limit, however, or indeed almost any restriction, on medically unnecessary MGC, they have made moves in the opposite direction. That is, they have begun to argue that (what they regard as) "minor" FGC—including not only ritual nicking as described above, but also, in the case of at least two such supporters, forcible retraction, cutting, or partial removal of the clitoral prepuce (see Box 1), and even total excision of the labia minora—should be considered morally and legally acceptable irrespective of medical necessity, with or without the consent of the affected person. Writing in the *Journal of Medical Ethics*, Kavita Shah Arora and Allan J. Jacobs state explicitly:

> [We] have argued elsewhere that [non-consensual, medically unnecessary] male circumcision does not constitute a human rights violation. [We] will assume the validity of this position [and] argue that a liberal society that tolerates expression of culture and/or religion in the manner of male circumcision should also permit certain

> de minimis [FGC] procedures. We believe this is an appropriate assumption because all Western nations in fact permit ritual circumcision of [male minors]. (132) (p. 149)

Similarly, in the federal court case we have been discussing, Harvard lawyer and vocal defender of ritual male circumcision, Alan Dershowitz (133), weighed in on the side of the defendants, that is, the members of the Dawoodi Bohra community alleged to have authorized or performed FGC on several young girls. In a news article entitled, "Alan Dershowitz explains why he is assisting a group accused of promoting female genital mutilation," the author states that in addition to consulting on crucial matters of legal strategy, Dershowitz advised the group to adopt a version of the Jewish (male) circumcision ritual known as *hatafat dam brit* (134). This involves piercing the genitals with a sharp instrument in order to draw blood, which, if applied to the vulva, would qualify as FGM Type IV on the WHO typology (20). In short, as the anthropologist Richard Shweder has argued: "what's good for the goose is good for the gander" (135).

Various scholars including myself have argued against such moves in recent publications, attempting to cast the *modus ponens* of Arora, Jacobs, Dershowitz, Shweder, and others as a *modus tollens* (or a reductio ad absurdum) (13,136–144). Nevertheless, following the publication of the article by Arora and Jacobs, the recommendation to permit medically unnecessary, non-consensual FGC was widely discussed in the media, and was ultimately endorsed by some mainstream commentators, including the editors of *The Economist* (145). Emboldened by these developments, defenders of what they call "female circumcision" have increasingly spoken out against the status quo, which they rightly suggest reflects Western cultural bias, moral hypocrisy, and sexist and religious double standards. Some groups, for example, have established professional websites to promote "minor" FGC (146–148), in some cases quoting verbatim from the 2012 policy of the AAP on newborn male circumcision to explain why their own practice should also be allowed.

Their quotations are not unjustified. According to the AAP task force members, including Dr. Freedman as mentioned earlier, reasonable people may disagree about what is in the overall best interest of an individual child, including with respect to the weight that should be assigned to potential health outcomes of circumcision compared to other factors. As the AAP task force states: "there are social, cultural, religious, and familial benefits and harms to be considered as well." And in their view, it is "reasonable to take these nonmedical benefits and harms for an individual into consideration when making a decision about [male] circumcision" (58) (p. e759). But if that is correct, then why is it not equally reasonable to take such nonmedical benefits and harms into account for female "circumcision"—and to likewise defer to the judgment of parents about the child's overall best interest—especially when considering those forms of FGC (such as ritual nicking) that are comparatively less severe than male circumcision?

Indeed, that was exactly the argument of the AAP in an earlier statement from 2010 on FGC (149). In its report, "Ritual genital cutting of female minors," the organization stated, "Some forms of FGC are less extensive than the newborn male circumcision commonly performed in the West" (150) (p. 1089). Moreover, in its then-current policy on such circumcision, the AAP "expresses respect for parental decision-making and acknowledges the legitimacy of including cultural, religious, and ethnic traditions when making the choice of whether to surgically alter a male infant's genitals." Putting two and two together: since nicking the vulva with a sharp object "is much less extensive than routine newborn male genital cutting [it] might be more effective if federal and state laws enabled pediatricians to reach out to families by offering a ritual nick as a possible compromise to avoid greater harm" (150) (p. 1092).

This suggestion was met with considerable resistance from anti-FGM advocates, feminists, and children's rights scholars, among many other stakeholders, and the policy was

retracted just one month later (151). Accordingly, the AAP, like the U.S. legal system, the WHO, and the Western discourse more generally, currently maintains two contradictory positions on medically unnecessary genital cutting: (a) it should never be performed for any reason on females under the age of 18, and (b) it should not be restricted, regardless of the reason, for males under the age of 18—quite apart from any details about the actual harms or motivations associated with one type of cutting versus the other. Again: this is not a sustainable situation.

Final thoughts

In previous work, I have argued that doctors are not ethically, and should not be professionally, permitted to take a sharp object to any child's genitals unless there is a relevant medical emergency (152–158). I will not rehearse all those arguments here. Briefly, however, even if the cutting is "just a little nick," it still carries risk, and it is reasonable to prefer that no such risk be concentrated on this particular part of one's body unless it is necessary to save one's life or health (and therefore preserve one's future bodily autonomy). It can also cause psychological harm to be held down and cut in such a personal way, especially as an infant or young child. And as an adult, it can it be (re)traumatising to learn about, and reflect on, what happened to one's genitals when one was too little to understand or resist.

The appropriate role of criminal law in discouraging genital cutting is a complex and contentious matter and I will not wade into that issue here (159–165). However, suppose that both FGC and MGC are—in line with the logic of the recent federal ruling—ultimately understood to constitute criminal assault. One recent suggestion is that "a legal ground for a personal exemption from punishment by exculpation might be considered" to avoid stigmatizing well-meaning parents as criminals (91) (p. 447). According to the authors of this

suggestion, legal scholars Reinhard Merkel and Holm Putzke: ‘to abstain from raising criminal charges would not, however, alter the fact that the [cutting] remains unlawful [as it] is definitionally a type of battery.” Even so, “in certain cases, the legislature may grant exceptional excuses under criminal law for certain widespread practices that are regularly performed without consciousness of their being unlawful [or] even under the dictate of a belief in a respective divine command” (91) (p. 447)

On this view, although explicitly religious genital cutting would be exempt from criminal punishment (while remaining illegal), non-religious genital cutting would indeed be subject to criminal prosecution “as soon as the grounds for a personal exemption from punishment were removed (that is, when the unlawful status of the cutting became sufficiently well known)” (41). In particular, physicians might face a special liability for knowingly performing medically unnecessary surgical procedures on persons who are within their care and not capable of giving consent (87). In a healthcare context, it is normally uncontroversial that *any* genital contact—including touching or fondling—that is not strictly required for diagnosis or treatment is at minimum a serious breach of the doctor’s fiduciary duties (166–168). Going forward, it will be important to ensure that all non-consenting persons are protected from such medically unnecessary interference with their genitals, regardless of race, ethnicity, sex, gender, gender identity, or parental religion.

In other words, instead of saying “what’s good for the goose is good for the gander,” perhaps we should be saying, “what’s good for the gander is good for the goose.”

References

1. Earp BD. ‘Unconstitutional’ US anti-FGM law exposes hypocrisy in child protection. The Conversation. 2019 Jan 11; Available from: https://theconversation.com/unconstitutional-us-anti-fgm-law-exposes-hypocrisy-in-child-protection-109305

2. Earp BD. Gender or genital autonomy? Why framing nontherapeutic genital cutting as a children's rights issue is both ethically and pragmatically necessary. Journal of Obstetrics and Gynaecology Canada. 2020;42(2):e17.

3. Belluck P. Federal ban on female genital mutilation ruled unconstitutional by judge. New York Times. 2018 Nov 21; Available from: https://www.nytimes.com/2018/11/21/health/fgm-female-genital-mutilation-law.html

4. Oppenheim M. Campaigners concerned after US law banning female genital mutilation is declared unconstitutional. The Independent. 2018 Nov 21; Available from: https://www.independent.co.uk/news/world/americas/fgm-us-law-female-ban-genital-mutilation-detroit-jumana-nagawala-a8645476.html

5. Friedman B. United States of America vs. Jumana Nagarwala et al. 2018. p. 28. Available from: https://www.scribd.com/document/393706333/Judge-dismisses-several-charges-in-FGM-case#download

6. Benner K. Justice dept. declines to defend law against female circumcision, citing flaws. New York Times. 2019 Apr 12; Available from: https://www.nytimes.com/2019/04/12/us/politics/justice-department-declines-defending-laws.html

7. Burke MN. Court declines House Democrats' motion to intervene in Michigan genital mutilation case. The Detroit News. 2019 Sep 14; Available from: https://www.detroitnews.com/story/news/politics/2019/09/14/court-declines-democrats-motion-intervene-michigan-genital-mutilation-case/2310965001/

8. Earp BD. Gender or genital autonomy? Why framing nontherapeutic genital cutting as a children's rights issue is both ethically and pragmatically necessary. Lecture presented at: National Secular Society Healthcare and Secularism Conference; 2018 Oct 27; Birmingham, England, UK. Available from: https://www.youtube.com/watch?v=GBH0g_Cl7Rk&t=1206s

9. Bond SL. State laws criminalizing female circumcision: a violation of the equal protection clause of the fourteenth amendment? J Marshall L Rev. 1998 1999;32:353–80.

10. Davis DS. Male and female genital alteration: a collision course with the law. Health Matrix. 2001;11(1):487–570.

11. Svoboda JS, Adler PW, Van Howe RS. Circumcision is unethical and unlawful. J Law Med Ethics. 2016;44(2):263–82.

12. Svoboda JS, Adler, Peter W., Van Howe RS. Is circumcision unethical and unlawful? A response to Morris et al. J Med Law Ethics. 2019;7(1):72–92.

13. Brussels Collaboration on Bodily Integrity. Medically unnecessary genital cutting and the rights of the child: moving toward consensus. Am J Bioeth. 2019;19(10):17–28.

14. Earp BD. The child's right to bodily integrity. In: Edmonds D, editor. Ethics and the Contemporary World. Abingdon and New York: Routledge; 2019. p. 217–35. Available from: https://www.academia.edu/37138614/The_childs_right_to_bodily_integrity

15. 18 U.S. Code § 116 - Female genital mutilation. Legal Information Institute. 1996. Available from: https://www.law.cornell.edu/uscode/text/18/116

16. Horowitz CR, Jackson JC. Female "circumcision." J Gen Intern Med. 1997;12(8):491–9.

17. Shell-Duncan B, Hernlund Y. Female "Circumcision" in Africa: Culture, Controversy, and Change. Boulder, CO: Lynne Rienner Publishers; 2000.

18. Oba AA. Female circumcision as female genital mutilation: human rights or cultural imperialism? Glob Jurist. 2008;8(3):1–38.

19. Taylor JR, Lockwood AP, Taylor AJ. The prepuce: specialized mucosa of the penis and its loss to circumcision. Brit J Urol. 1996;77(2):291–295.

20. WHO/UN. Eliminating female genital mutilation: an interagency statement. World Health Organization; 2008. Available from: https://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/

21. Serour GI. The issue of reinfibulation. Int J Gynaecol Obstet. 2010;109(2):93–6.

22. Myers A, Earp BD. What is the best age to circumcise? A medical and ethical analysis. Bioethics. 2020;in press.

23. Cold CJ, Taylor JR. The prepuce. BJU Int. 1999;83(S1):34–44.

24. Wahlberg A, Påfs J, Jordal M. Pricking in the African diaspora: current evidence and recurrent debates. Curr Sex Health Rep. 2019;5(1):1–7.

25. Byrne E. Even "symbolic" female genital mutilation illegal, High Court rules. ABC News. 2019. Available from: https://www.abc.net.au/news/2019-10-16/high-court-rules-female-genital-mutilation-illegal-in-all-forms/11606396

26. Hodson N, Earp BD, Townley L, Bewley S. Defining and regulating the boundaries of sex and sexuality. Med Law Rev. 2019;27(4):541–52.

27. Monro S, Crocetti D, Yeadon-Lee T, Garland F, Travis M. Intersex, variations of sex characteristics and DSD: the need for change. University of Huddersfield; 2017. Available from: http://eprints.hud.ac.uk/id/eprint/33535/

28. Carpenter M. Intersex. In: Oxford Bibliographies. Oxford: Oxford University Press; 2020.

29. Hurwitz RS. Feminizing surgery for disorders of sex development: evolution, complications, and outcomes. Curr Urol Rep. 2011 Apr 1;12(2):166–72.

30. Carpenter M. The "normalization" of intersex bodies and "othering" of intersex identities in Australia. J Bioeth Inq. 2018;15(4):487–95.

31. Liao L-M, Hegarty P, Creighton SM, Lundberg T, Roen K. Clitoral surgery on minors: an interview study with clinical experts of differences of sex development. BMJ Open. 2019;9(6):e025821.

32. Dreger A. Intersex in the Age of Ethics. Hagerstown: University Publishing Group; 1999.

33. Reis E. Did bioethics matter? A history of autonomy, consent, and intersex genital surgery. Med Law Rev. 2019;27(4):658–74.

34. Reis-Dennis S, Reis E. Are physicians blameworthy for iatrogenic harm resulting from unnecessary genital surgeries? AMA J Ethics. 2017;19(8):825–33.

35. Creighton SM, Minto C. Managing intersex. BMJ. 2001;323(7324):1264–5.

36. Yaeger L. Model Hanne Gaby odiele on what it means to be intersex—and why she's going public . Vogue. 2016. Available from: https://www.vogue.com/article/hanne-gaby-odiele-model-intersex-interview

37. Human Rights Watch. "I want to be like nature made me." Medically unnecessary surgeries on intersex children in the US. Human Rights Watch. 2017. Available from: https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us

38. Karkazis K. Fixing Sex: Intersex, Medical Authority, and Lived Experience. Durham: Duke University Press; 2008.

39. Reis E. Bodies in Doubt: An American History of Intersex. Baltimore: JHU Press; 2009.

40. Quigley CA, Bellis AD, Marschke KB, El-Awady MK, Wilson EM, French FS. Androgen receptor defects: historical, clinical, and molecular perspectives. Endocr Rev. 1995;16(3):271–321.

41. Earp BD, Johnsdotter S. Current critiques of the WHO policy on female genital mutilation. IJIR. 2020;in press.

42. Dembroff R. Beyond binary: genderqueer as critical gender kind. Philos Imp. 2019;online ahead of print.

43. Richards C, Bouman WP, Seal L, Barker MJ, Nieder TO, T'Sjoen G. Non-binary or genderqueer genders. Int Rev Psychiatr. 2016;28(1):95–102.

44. Earp BD. What is gender for? Philosopher. 2020;in press.

45. Bettcher TM. Feminist perspectives on trans issues. In: Zalta EN, editor. The Stanford Encyclopedia of Philosophy . Spring 2014. Metaphysics Research Lab, Stanford University; 2014.

46. Gollaher DL. From ritual to science: the medical transformation of circumcision in America. J Soc Hist. 1994;28(1):5–36.

47. Hodges F. A short history of the institutionalization of involuntary sexual mutilation in the United States. In: Sexual Mutilations. New York: Springer; 1997. p. 17–40.

48. Hodges FM. The antimasturbation crusade in antebellum American medicine. J Sex Med. 2005;2(5):722–31.

49. Wallerstein EJ. Circumcision: the uniquely American medical enigma. Urol Clin North Am. 1985;12(1):123–32.

50. WHO. Male circumcision: global trends and determinants of prevalence, safety, and acceptability. Geneva: World Health Organization: UNAIDS; 2008 p. 1–35.

51. Earp BD, Shaw DM. Cultural bias in American medicine: the case of infant male circumcision. J Pediatr Ethics. 2017;1(1):8–26.

52. Bossio JA, Pukall CF, Steele SS. Examining penile sensitivity in neonatally circumcised and intact men using quantitative sensory testing. J Urol. 2016;195(6):1848–53.

53. Rotta AT. Re: "Examining penile sensitivity in neonatally circumcised and intact men using quantitative sensory testing." J Urol. 2016;196(6):1822–3.

54. Earp BD. Infant circumcision and adult penile sensitivity: implications for sexual experience. Trends Urol Men Health. 2016 Jul 1;7(4):17–21.

55. Fahmy MAB. Anatomy of the prepuce. In: Normal and Abnormal Prepuce. Cham: Springer International Publishing; 2020. p. 35–57.

56. Fahmy MAB. Nonaesthetic circumcision scarring. In: Fahmy MAB, editor. Complications in Male Circumcision. Elsevier; 2019. p. 99–134.

57. Glick LB. Marked in Your Flesh: Circumcision from Ancient Judea to Modern America. Oxford: Oxford University Press; 2005.

58. AAP. Male circumcision (technical report). Pediatr. 2012;130(3):e756–85.

59. CDC. Information for providers to share with male patients and parents regarding male circumcision and the prevention of HIV infection, sexually transmitted infections, and other health outcomes. U.S. Centers for Disease Control and Prevention; 2018 p. 1–13. Available from: https://stacks.cdc.gov/view/cdc/58456

60. Frisch M, Aigrain Y, Barauskas V, Bjarnason R, Boddy S-A, Czauderna P, et al. Cultural bias in the AAP's 2012 technical report and policy statement on male circumcision. Pediatr. 2013;131(4):796–800.

61. Van Howe RS. A CDC-requested, evidence-based critique of the Centers for Disease Control and Prevention 2014 draft on male circumcision: How ideology and selective science lead to superficial, culturally-biased recommendations by the CDC. U.S. Centers for Disease Control and Prevention; 2015 p. 1–208. Available from: https://www.researchgate.net/publication/271841897.

62. Kupferschmid C, Barauskas V, Bjarnason R, Boddy S-A, Czauderna P, Fasching G, et al. Commentary on the CDC “Recommendations for providers counseling male patients and parents regarding male circumcision and the prevention of HIV infection, STIs, and other health outcomes." U.S. Centers for Disease Control and Prevention; 2015 p. 1–6. Available from: http://www.regulations.gov/#!documentDetail;D=CDC-2014-0012-2455

63. Earp BD. Do the benefits of male circumcision outweigh the risks? A critique of the proposed CDC guidelines. Front Pediatr. 2015;3(18):1–6.

64. Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. Deeks S, editor. PLOS Med. 2005;2(11):e298.

65. Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. Lancet. 2007;369(9562):643–56.

66. Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S, Nalugoda F, et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. Lancet. 2007;369(9562):657–66.

67. Bell K. HIV prevention: making male circumcision the ‘right’ tool for the job. Glob Pub Health. 2015;10(5–6):552–72.

68. Giami A, Perrey C, de Oliveira Mendonça AL, de Camargo KR. Hybrid forum or network? The social and political construction of an international ‘technical consultation’: Male circumcision and HIV prevention. Glob Pub Health. 2015;10(5–6):589–606.

69. Garenne M, Giami A, Perrey C. Male circumcision and HIV control in Africa: questioning scientific evidence and the decision-making process. In: Giles-Vernik T, Webb J, editors. Global Health in Africa: Historical Perspectives on Disease Control. Athens: Ohio University Press; 2013. p. 185–210.

70. Berer M. Male circumcision for HIV prevention: perspectives on gender and sexuality. Reprod Health Matters. 2007;15(29):45–8.

71. Fox M, Thomson M. HIV/AIDS and male circumcision: discourses of race and masculinity. In: Fineman MA, Thomson M, editors. Exploring Masculinities. Farnham, UK: Ashgate; 2016. p. 97–113.

72. Bossio JA, Pukall CF, Steele SS. A review of the current state of the male circumcision literature. J Sex Med. 2014;11(12):2847–64.

73. Bundick S. Promoting infant male circumision to reduce transmission of HIV: a flawed policy for the US. Harvard Health and Human Rights Journal Blog. 2009. Available from: https://www.hhrjournal.org/2009/08/promoting-infant-male-circumcision-to-reduce-transmission-of-hiv-a-flawed-policy-for-the-us/

74. Frisch M, Earp BD. Circumcision of male infants and children as a public health measure in developed countries: a critical assessment of recent evidence. Glob Pub Health. 2018;13(5):626–641.

75. CPS. Newborn male circumcision. Paediatr Child Health. 2015;20(6):311–320.

76. RACP. Circumcision of infant males. Royal Australasian College of Physicians. 2010;1–28.

77. Freedman AL. The circumcision debate: beyond benefits and risks. Pediatr. 2016;137(5):e20160594.

78. AAP. The AAP Task Force on Neonatal Circumcision: A call for respectful dialogue. J Med Ethics. 2013;39(7):442–3.

79. AAP. Cultural bias and circumcision: The AAP task force on circumcision responds. Pediatr. 2013;131(4):801–4.

80. Duivenbode R, Padela AI. Female genital cutting (FGC) and the cultural boundaries of medical practice. Am J Bioeth. 2019;19(3):3–6.

81. Merwin T. Fleshing out change on circumcision. Jewish Week. 2012 Sep 19. Available from: http://jewishweek.timesofisrael.com/fleshing-out-change-on-circumcision/

82. Kessler SJ. The medical construction of gender: case management of intersexed infants. Signs. 1990;16(1):3–26.

83. Ainsworth C. Sex redefined. Nature News. 2015;518(7539):288–91.

84. Fausto-Sterling A. Gender/sex, sexual orientation, and identity are in the body: how did they get there? J Sex Res. 2019;56(4–5):529–55.

85. Fausto-Sterling A. The five sexes, revisited. In: Zinn MB, Hondagneu-Sotelo P, Messner MA, editors. Gender Through the Prism of Difference. Oxford: Oxford University Press; 2016.

86. Clarke JA. They, them, theirs. Harv L Rev. 2019;132:895–991.

87. Adler PW, Van Howe RS, Wisdom T, Daase F. Is circumcision a fraud? Cornell J L Pub Pol'y. in press;

88. Brigman WE. Circumcision as child abuse: the legal and constitutional issues. J Fam L. 1984 1985;23(3):337–57.

89. Kellner NI. Under the knife: female genital mutilation as child abuse. J Juv L. 1993;14:118–32.

90. Boyle GJ, Svoboda J, Price C, Turner JN. Circumcision of healthy boys: criminal assault? J Law Med. 2000;7(February):301–10.

91. Merkel R, Putzke H. After Cologne: male circumcision and the law. Parental right, religious liberty or criminal assault? J Med Ethics. 2013;39(7):444–9.

92. Ford K-K. “First, do no harm”: the fiction of legal parental consent to genital-normalizing surgery on intersexed infants. Yale L Pol'y Rev. 2001;19(2):469–488.

93. Somerville M. The Ethical Canary: Science, Society, and the Human Spirit. London: McGill-Queen’s University Press; 2004. 363 p.

94. Adler PW. Is circumcision legal? Richmond J L Pub Interest. 2012;16(3):439–83.

95. Svoboda JS, Van Howe RS, Dwyer JG. Informed consent for neonatal circumcision: an ethical and legal conundrum. J Contemp Health L & Pol’y. 2000;17(1):61–134.

96. Warren N, Tower C. Risk, harm, and prevention of female genital cutting in the U.S. Arch Sex Behav. 2020;online ahead of print.

97. Earp BD. Female genital mutilation and male circumcision: toward an autonomy-based ethical framework. Medicolegal Bioeth. 2015;5(1):89–104.

98. DeLaet DL. Framing male circumcision as a human rights issue? Contributions to the debate over the universality of human rights. J Hum Rts. 2009;8(4):405–26.

99. Rogers J. The first case addressing female genital mutilation in Australia: Where is the harm? Alt Law J. 2016;41(4):235–238.

100. Earp BD. On the supposed distinction between culture and religion: A brief comment on Sir James Munby’s decision in the matter of B and G (children). Practical Ethics (University of Oxford). 2015.

101. Munby SJ. In the matter of B and G (Children). 2015. Available from: https://www.judiciary.uk/wp-content/uploads/2015/01/BandG_2_.pdf

102. Brusa M, Barilan YM. Cultural circumcision in EU public hospitals - an ethical discussion. Bioethics. 2009;23(8):470–82.

103. Bootwala. A review of female genital cutting (FGC) in the Dawoodi Bohra community: parts 1, 2, and 3. Curr Sex Health Rep. 2019;11(3):212–35.

104. Abdulcadir J, Ahmadu FS, Essen B, Gruenbaum E, Johnsdotter S, Johnson MC, et al. Seven things to know about female genital surgeries in Africa. Hastings Cent Rep. 2012;42(6):19–27.

105. Johnsdotter S. Girls and boys as victims: asymmetries and dynamics in European public discourses on genital modifications in children. In: Fusaschi M, Cavatorta G, editors. FGM/C: From Medicine to Critical Anthropology. Turin: Meti Edizioni; 2018. p. 31–50.

106. Wahlberg A, Essén B, Johnsdotter S. From sameness to difference: Swedish Somalis' post-migration perceptions of the circumcision of girls and boys. Cult Health Sex. 2019;21(6):619–35.

107. Taher M. Understanding female genital cutting in the Dawoodi Bohra community: an exploratory survey. Sahiyo: United Against Female Genital Cutting; 2017 p. 1–82. Available from: https://sahiyo.files.wordpress.com/2017/02/sahiyo_report_final-updatedbymt2.pdf

108. Price C. Male circumcision: an ethical and legal affront. Bull Med Ethics. 1997;128:13–9.

109. Otterman S. Denouncing city's move to regulate circumcision. The New York Times. 2012 Sep 12. Available from: https://www.nytimes.com/2012/09/13/nyregion/regulation-of-circumcision-method-divides-some-jews-in-new-york.html

110. Sifferlin A. How 11 New York City babies contracted herpes through circumcision. Time. 2012 Jun 7; Available from: https://healthland.time.com/2012/06/07/how-11-new-york-city-babies-contracted-herpes-through-circumcision/

111. Grynbaum MM. New York City health board repeals rule on consent forms for circumcision ritual. The New York Times. 2015 Sep 9. Available from: https://www.nytimes.com/2015/09/10/nyregion/new-york-city-health-board-repeals-rule-on-consent-forms-for-circumcision-ritual.html

112. NYC Health. Metzitzah b'peh (direct oral suctioning) [Internet]. 2020. Available from: https://www1.nyc.gov/site/doh/health/health-topics/safe-bris.page

113. NYC Health. Female circumcision (FC) [Internet]. 2020. Available from: https://www.health.ny.gov/community/adults/women/female_circumcision/

114. Earp BD. Does female genital mutilation have health benefits? The problem with medicalizing morality. Practical Ethics (University of Oxford). 2017. Available from: http://blog.practicalethics.ox.ac.uk/2017/08/does-female-genital-mutilation-have-health-benefits-the-problem-with-medicalizing-morality/

115. Raja T. I underwent genital mutilation as a child—right here in the United States. Mother Jones. 2017. Available from: http://www.motherjones.com/politics/2017/04/genital-cutting-indian-doctor-women-khatna/

116. Darby R, Svoboda JS. A rose by any other name? Rethinking the similarities and differences between male and female genital cutting. Med Anthropol Q. 2007;21(3):301–23.

117. Svoboda JS. Promoting genital autonomy by exploring commonalities between male, female, intersex, and cosmetic female genital cutting. Glob Disc. 2013;3(2):237–55.

118. Saalih al-Munajjid M. Medical benefits of female circumcision. Islam Question & Answer. 2020. Available from: https://islamqa.info/en/answers/45528/medical-benefits-of-female-circumcision

119. Mohamed Ali SEK. Safe female circumcision. Khartoum, Sudan: Khartoum University; 2009. Available from: http://umatia.org/2011/safecircumcision.html

120. Hussein A. Female circumcision: an Islamic practice brings untold benefits to women. Daily Mirror. 2018. Available from: http://www.dailymirror.lk/opinion/Female-Circumcision-An-Islamic-practice-brings-untold-benefits-to-women/172-155646

121. Dhumieres M. The custom of female circumcision remains good business in Indonesia. Public Radio International. 2015. Available from: https://www.pri.org/stories/custom-female-circumcision-remains-good-business-indonesia

122. al-Haj H. Female circumcision. Assembly of Muslim Jurists of America. 2010. Available from: https://www.amjaonline.org/fatwa/en/81556/female-circumcision

123. Bhalla N. Female circumcision in Sri Lanka is “just a nick,” not mutilation: supporters. Jakarta Globe. 2017 Nov 28. Available from: https://jakartaglobe.id/news/female-circumcision-sri-lanka-just-nick-not-mutilation-supporters

124. Ahmadu FS, Shweder RA. Disputing the myth of the sexual dysfunction of circumcised women. Anthropol Today. 2009;25(6):14–17.

125. Darby R. Moral hypocrisy or intellectual inconsistency? A historical perspective on our habit of placing male and female genital cutting in separate ethical boxes. Kennedy Inst of Ethics J. 2016;26(2):155–163.

126. Shahvisi A, Earp BD. The law and ethics of female genital cutting. In: Creighton SM, Liao L-M, editors. Female Genital Cosmetic Surgery: Solution to What Problem? Cambridge: Cambridge University Press; 2019. p. 58–71.

127. Morris BJ, Waskett JH, Banerjee J, Wamai RG, Tobian AA, Gray RH, et al. A “snip” in time: What is the best age to circumcise? BMC Pediatr. 2012;12(20):1–15.

128. Earp BD, Hendry J, Thomson M. Reason and paradox in medical and family law: shaping children’s bodies. Med Law Rev. 2017;25(4):604–27.

129. Mason C. Exorcising excision: medico-legal issues arising from male and female genital surgery in Australia. J Law Med. 2001;9(1):58–67.

130. Dustin M. Female genital mutilation/cutting in the UK: challenging the inconsistencies. Euro J Women’s Stud. 2010;17(1):7–23.

131. Ahmadu FS. Equality, not special protection: multiculturalism, feminism, and female circumcision in Western liberal democracies. In: Cassaniti J, Menon U, editors. Universalism Without Uniformity: Explorations in Mind and Culture. Chicago: University of Chicago Press; 2017. p. 214–36.

132. Arora KS, Jacobs AJ. Female genital alteration: a compromise solution. J Med Ethics. 2016;42(3):148–54.

133. Dershowitz A. J'Acuse: shame on Germany for circumcision ban. Algemeiner.com. 2012. Available from: http://www.algemeiner.com/2012/09/06/j%E2%80%99acuse-shame-on-germany-for-circumcision-ban/

134. Sales B. Alan Dershowitz explains why he is assisting a group accused of promoting female genital mutilation. Jewish Telegraphic Agency. 2017 Jun 12; Available from: https://www.jta.org/2017/06/12/united-states/alan-dershowitz-explains-why-he-is-assisting-a-group-accused-of-promoting-female-genital-mutilation

135. Shweder RA. The goose and the gander: the genital wars. Glob Disc. 2013;3(2):348–66.

136. Earp BD. In defence of genital autonomy for children. J Med Ethics. 2016;42(3):158–63.

137. Earp BD. Online appendix to "In defence of genital autonomy for children." J Med Ethics. 2016;42(3-online supplement):1–22.

138. Steinfeld R, Earp BD. Could efforts to eliminate female genital cutting be strengthened by extending protections to male and intersex children? Reprod Health. 2017;14(S2):115–115.

139. Earp BD, Steinfeld R. Gender and genital cutting: a new paradigm. In: Barbat TG, editor. Gifted Women, Fragile Men. Brussels: ALDE Group-EU Parliament. 2017. (Euromind Monographs).

140. Munzer SR. Examining nontherapeutic circumcision. Health Matrix. 2018;28(1):1–77.

141. Möller K. Male and female genital cutting: between the best interests of the child and genital mutilation. Ox J Legal Stud. 2020;in press.

142. Johnson-Agbakwu CE, Manin E. Sculptors of african women's bodies: forces reshaping the embodiment of female genital cutting in the West. Arch Sex Behav. 2020;online ahead of print.

143. Townsend KG. The child's right to genital integrity. Philos Soc Crit. 2019;online ahead of print.

144. Lunde IB, Hauge M-I, Johansen REB, Sagbakken M. 'Why did I circumcise him?' Unexpected comparisons to male circumcision in a qualitative study on female genital cutting among Kurdish–Norwegians. Ethnicities. 2020;online ahead of print.

145. Editors. The unkindest cut. The Economist. 2016 Jun 18. Available from: https://www.economist.com/international/2016/06/18/the-unkindest-cut

146. FC Myths & Facts. Consent and parental rights. Female Circumcision. 2018. Available from: https://femalecircumcision.org/consent-and-parental-rights/

147. FC Myths & Facts. A problem of definition: female circumcision vs FGM. Female Circumcision. 2018. Available from: https://femalecircumcision.org/a-problem-of-definition-female-circumcision-vs-fgm/

148. FC Myths & Facts. The social construction of female circumcision: gender, equality, and culture. Female Circumcision. 2018. Available from: https://femalecircumcision.org/the-social-construction-of-female-circumcision-gender-equality-and-culture/

149. Van Howe RS. The American Academy of Pediatrics and female genital cutting: when national organizations are guided by personal agendas. Ethics Med. 2011;27(3):165–74.

150. AAP. Ritual genital cutting of female minors. Pediatr. 2010;125(5):1088–93.

151. MacReady N. AAP retracts statement on controversial procedure. Lancet. 2010;376(9734):15.

152. Earp BD. Male circumcision: Who should decide? Pediatr. 2016;37(5):e-letter.

153. Earp BD. The ethics of infant male circumcision. J Med Ethics. 2013;39(7):418–420.

154. Earp BD. Sex and circumcision. Am J Bioeth. 2015;15(2):43–5.

155. Earp BD. The AAP report on circumcision: Bad science + bad ethics = bad medicine. Practical Ethics (University of Oxford). 2012 Aug 29; Available from: http://blog.practicalethics.ox.ac.uk/2012/08/the-aap-report-on-circumcision-bad-science-bad-ethics-bad-medicine/

156. Earp BD, Steinfeld R. Genital autonomy and sexual well-being. Curr Sex Health Rep. 2018;10(1):7–17.

157. Earp BD. Boys and girls alike: the ethics of male and female circumcision. In: Gathman ECH, editor. Women, Health, & Healthcare: Readings on Social, Structural, & Systemic Issues. Dubuque, IA: Kendall Hunt Publishing Company; 2016. p. 113–6.

158. Carmack A, Notini L, Earp BD. Should surgery for hypospadias be performed before an age of consent? J Sex Res. 2016;53(8):1047–58.

159. Berer M. The history and role of the criminal law in anti-FGM campaigns: Is the criminal law what is needed, at least in countries like Great Britain? Reprod Health Matters. 2015;23(46):145–57.

160. Berer M. Prosecution of female genital mutilation in the United Kingdom: Injustice at the intersection of good public health intentions and the criminal law. Med Law Int 2019;19(4):258–81.

161. Nwogu S. Don’t criminalise female circumcision. Punch Magazine. 2018. Available from: http://punchng.com/dont-criminalise-female-circumcision-cmo/

162. Johnsdotter S. Meaning well while doing harm: compulsory genital examinations in Swedish African girls. Sex Reprod Health Matters. 2019;27(2):1–13.

163. Townley L, Bewley S. Why the law against female genital mutilation should be scrapped. The Conversation. 2017. Available from: http://theconversation.com/why-the-law-against-female-genital-mutilation-should-be-scrapped-79851

164. Notini L, Earp BD. Should Iceland ban circumcision? A legal and ethical analysis. Practical Ethics (University of Oxford). 2018 Apr 21; Available from: http://blog.practicalethics.ox.ac.uk/2018/04/should-iceland-ban-circumcision-a-legal-and-ethical-analysis/

165. Balashinsky D. In support of Iceland's proposed involuntary-circumcision ban. Letter to the Icelandic Alþingi. 2018. Available from: https://dbalablog.blogspot.com/2018/11/in-support-of-icelands-proposed_11.html

166. Bruce L. A pot ignored boils on: sustained calls for explicit consent of intimate medical exams. HEC Forum. 2020;online ahead of print.

167. Barnes SS. Practicing pelvic examinations by medical students on women under anesthesia: Why not ask first? Obstet Gynecol. 2012;120(4):941–3.

168. Rabin RC. How to keep children safe from abuse at the doctor's office. The New York Times. 2018 Jan 26. Available from: https://www.nytimes.com/2018/01/26/well/family/lawrence-nassar-gymnastics-doctors-pediatricians-safety.html