**CONSENSUAL REINFIBULATION: IN SUPPORT OF A COMPROMISING POSITION BETWEEN AUTONOMY AND NONMALEFICENCE**

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**ABSTRACT**

**Background**: Because of the increasing number of African and Asian migrants, reinfibulation is expected to become a bigger problem for European physicians. Reinfibulation is considered prohibited as it constitutes a highly debated non-western type “non-therapeutic female genital modification”. I make the major assumption that under certain circumstances consensual reinfibulation may be permissible in western-type societies. In this paper I support this assumption and explore the circumstances that should hold for consensual reinfibulation to be permissible.

**Discussion:** A high-sensitive and deep non systematic review of the most relevant literature regarding mainly the topic of the so-called “female genital mutilation” (as well as “male genital mutilation” and “cosmetic genital surgery”) has been carried out. Taking into consideration the relational account of autonomy and the holistic account of health, I argue that autonomously chosen reinfibulation might be considered as “therapeutic” (in broad sense and from any cultural viewpoint) and consequently permissible practice. When certain conditions hold, reinfibulation may be a rather beneficial to (broadly understood) health practice, whereas it may be not harmful to woman’s sexuality. Besides, I propose what conditions would have to hold for a woman’s request to be considered “autonomous” so that to justify the reinfibulation as a “therapeutic” practice. Moreover, under certain circumstances reinfibulation does not cause noticeable other-regarding symbolic harm.

**Conclusion:** Consensual reinfibulationmay be permissible when is clearly beneficial to the woman’s health (in broad sense) / well-beingand her desire to have reinfibulation carried out on her body is based on “thick enough” autonomy.

**INTRODUCTION**

According to the WHO/UNICEF/UNFPA Joint Statement infibulation (type III of what is conflated under the term “Female Genital Mutilation”) is “narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris” [1] . It is an extensive (and most severe) form of “non-therapeutic female genital cutting/altering” (NTFGC/A) practices which vary considerably across cultures as is emphasized by the scholarship of the last 10-15 years [2] . Occasionally, it may be necessary for an infibulated woman that a reverse of infibulation (de-infibulation) be carried out on her body, for medical or other reasons (e.g. first intercourse). It is stated that de-infibulation “is the procedure used to reverse infibulation, to create a normal vaginal opening and to rebuild, medically speaking, a sort of “normal” anatomy of external mutilated genitals, respectful of their function also from the patient’s eyes” [3]. Re-infibulation is a (hygienic when performed by physician) procedure by which “the vulva is sutured to restore its infibulated appearance” [4]. It is a roughly reversible genital alteration that does not involve removal of healthy tissue, except in the cases of the medical indications. It is subtly different than “infibulation”. Anatomic deformations resulted from repeated re-infibulations should be treated during a reinfibulation procedure [5].

Despite legal prohibition reinfibulation is performed by health professionals in many countries of the world [6]. In Belgium gynecologists feel confused about the admissibility of reinfibulation [4]. Moreover, physicians may be forced to perform (partial) reinfibulation to prevent infections or fusion between the tissues while it remains unclear to what extent is it permitted [5].

As it is pointed out here, reinfibulation is not an issue of either permitting or banning. A deinfibulated woman to whom reinfibulation *may* *be beneficial* for her health (broadly understood) and well-being, and who a) as infibulated was not suffering from long-lasting complications, b) the infibulation had not eliminated her capability of achieving sexual pleasure or even reaching orgasm and/or the deinfibulation is not expected to significantly improve her sexuality, *might* (after individual assessment) be allowed to have reinfibulation carried out on her body, on the condition that she has made such an autonomous choice herself. In this direction, I explore the conditions that have to hold for a reinfibulation to be considered permissible. A medical treatment (in the strict sense) may involve a severe bodily injury. A “medical” treatment (in the broad sense) should involve a proportionally less severe bodily injury. In my opinion this is the case with reinfibulation (that does not cause long-term complications or impairment of sexual activity). Reinfibulation is a hygienic, (roughly) reversible major genital alteration.

Here is presented a compromising position between autonomy and nonmaleficence as well as between relativism and universalism. It is not respectful of the woman’s minority culture itself. However, environmental factors that reflect cultural values slip into what is meant to be “health/well-being status” (valuable for all cultures) and “autonomous choice”, thus determining the relative weight of each principle when the principles of beneficence and nonmaleficence enter into conflict, and thus determining which principle will be the overriding one. Furthermore, I reflect on autonomy of a woman who seeks to undergo reinfibulation.

**THE WHO**

It is should be emphasized that WHO has conflated under the undifferentiated heading “FGM” (Female Genital Mutilation) the full range of NTFGC/A procedures, under any circumstance, to any degree and with any instrument, as long as “non-therapeutic” (strictly understood) [7]. However, the characterization “FGM” is controversial [8] and extremely superficial and reductive as well [2]. Besides, it is an over-simplistic and misleading characterization. The all-catching term “FGM” collapses together the most extreme, harmful and unhygienic forms of NTFGC/A with the most minor and hygienic forms (carried out in a hospital setting with sterile instruments). NTFGC/A needs a much more nuanced approach. Many of them do not involve removal of healthy tissue. They probably involve only genital alteration or a minimal completely healable injury. As I point out here, reinfibulation may be a “therapeutic” (broadly understood) practice which, however, for the WHO falls under the term “non-therapeutic”.

**“RESPECT FOR THE FOREIGN CULTURE”: TO WHAT EXTENT?**

Recently, Arora and Jacobs [9], attempting a compromising position between principle of nonmaleficence and respect for the foreign culture, argued that a “minimal procedure” that has not lasting consequences on genital’s morphology or function can be accepted as a compromising and harm reducing attitude. Their proposal has faced strong criticism by scholars for involving internal inconsistencies [10], perpetuating submission of women [11] and being disrespectful of the autonomy [10] (the “genital autonomy” of the girl) [12]. It should not be overlooked that there are strong arguments against such a position such as perpetuation of oppression of women. However, such a Western-type inflammatory rhetoric is simplistic and may result in rushing to ‘dark judgments about little known others.’ [7]. A minimal alteration (e.g. prick) to a girl’s genitals that in all likelihood would significantly support her to plan for her future well-being and fulfilment within the cultural context and core values of her community, might be considered proportional (insignificant burden to obtain significant benefits) and therefore ethically accepted. Further, when it comes to consensual NTFGC/A it is noticeable that Western theorists (Christman 2004, 152; Westlund 2009, 29) argue that ‘women subject to constraining practices’ ‘could autonomously accept their conditions’ (Stanford Encyclopedia, 2013). Meyers writes that “there are women [participating in the practice of female genital cutting] who conclude that cultural tradition or cohesion or getting married and bearing children are more important than bodily integrity” and that therefore “we would need far more consensus than we presently have (or are likely to get)…before we could conclude that women who opt for compliance with female genital cutting norms never do so autonomously” (Meyers 2000a, 479). In light of a weak substantive account of autonomy (Benson 2005) according to which a woman can autonomously comply with oppressive gender norms. Stoljar puts the issue of motivation in play and claims that ‘a woman loses autonomy only when oppressive feminine norms carry excessive weight in her life from an objective or a subjective standpoint.’ (Veltman and Piper 2014)

An assumption invoked in the argumentation of Arora and Jacobs is that male circumcision is a broadly accepted practice. It is argued that, with the exception of extreme forms, between NTFGC/A and male circumcision there are strong similarities and overlap regarding the forms, the methods, the rationales and the consequences for health and sexuality [2, 7, 8, 13, 14]. In societies where practice customary NTFGC/A male circumcision is equally accepted and performed practice [2]. The acceptance of male circumcision (though not of minimal forms of NTFGC/A) is a gender-based double standard approach [7]. In my opinion, there are no morally relevant differences between customary male circumcision and (minimal forms) of customary female circumcision. Both are traditional practices causing (not severe) anatomic alterations to external genitals and having long-term negative consequences in physical and sexual health that are mostly insignificant. The assumption that male circumcision is a beneficial practice is morally troublesome and should be dismissed as implausible. Such an assumption has already been isolated by a major part of scholarship [10, 15, 16]. Although male circumcision does not appear to adversely affect penile sexual function or sensitivity, further research is needed for a better affirmation of this assumption. (Ye Tian et al. 2013)

**THE HARMFULNESS OF (RE)INFIBULATION**

Infibulation may be harmful to physical and mental health. It may cause long-term medical complications [5]. In such a case reinfibulation cannot be considered beneficial for health/well-being. However the harms caused by infibulation are not always as significant as western societies believe [17]. Infibulated Somali immigrant women reported “overall best health” [17]. Other studies reported no causal relationship between infibulation and obstetric complications [17]. One out of ten Somali women living in the UK reported that infibulation was a traumatic experience which, however, did not affect her life “afterwards” [18]. Other women reported no impact (or even positive impact) of infibulations on their mental health [19]. However, these are not undoubtedly reliable studies [20].

**THE REQUEST FOR REINFIBULATION**

Women’s request to be reinfibulated after being deinfibulated seems to be a strong request that is caused by both internal pressures (resulted from maladaptation to the changes in the body post deinfibulation) and external pressures (social and cultural pressures). Bello et al. (2017) argue that there is no evidence to conclude that counselling before deinfibulation influences rates of request for reinfibulation.

Further, in a Greek studywhich was carried out in 2009 by the 2nd Department of Obstetrics and Gynecology of Aretaieion Hospital in Athens, 3 out of 7 women answered positively to the hypothetical question whether they would like to undergo reinfibulation after vaginal delivery (Vrachnis et al. 2012).

**INFIBULATION, DEINFIBULATION AND REINFIBULATION: MORALLY DIFFERENT PRACTICES**

It is beyond the scope of this paper to explore the ethicality of infibulation. Regardless of its ethicality, infibulation is practised in several African and Asian countries. As migration flows from these countries to Europe increases the rates of request for reinfibulation (after deinfibulation being necessarily performed for obstetrician or other medical reasons) are at increase, thus making its ethicality a topic of increasing concern. In my opinion, although infibulation and reinfibulation are ontologically similar practices, they are completely different from a moral standpoint. Infibulation is a permanent and perhaps severe alteration of female genital’s anatomy. It is a radical intervention to a highly valuable part of female body. Nevertheless, reinfibulation is restoring to a former condition. Ethically accepted reinfibulation does not automatically mean ethically accepted infibulation.

**POTENTIAL BENEFITS TO HEALTH AND WELL-BEING**

The holistic theories of health significantly blur the distinction between health and well-being. Whatever promotes the sense of well-being may be considered as medical treatment (in a broad sense). According to Richman’s theory of “embedded instrumentalism”, health is a matching between one’s abilities “*qua organism*” and goals “*qua person*” [21]. Well-being is a considerably broad concept including subjective/psychological/mental and relational/social well-being, two overlapping and interacting dimensions of it. The subjective/psychological well-being goes beyond the individual. It is informed by the individual’s relations. The relational well-being is a multi-dimensional dynamic interactive process that goes clearly beyond the individual and concerns the net of interpersonal relationships wherein the individual is embedded.

As is presented below, deinfibulation may be harmful or risky for woman’s total health (broadly understood as mismatching between woman’s abilities “*qua organism*” and her goals “*qua person*). Therefore, reinfibulation may prevent the status of a woman’s health (broadly understood) and well-being from getting worse through de-infibulation. To be clear, reinfibulation may be beneficial for woman’s total health (understood broadly) and (sense of) well-being when, all things considered, is instrumental in: a) Fostering her relational well-being. b) Fostering (or restoring) her subjective/psychological well-being.

My position shares some features with Earp’s one. He evaluates NTFGC/A by drawing on ‘the biomedical “enhancement” literature’. Earp argues that it should be considered permissible for parents to “make decisions that are instrumental to the promotion of their *child’s* overall well-being, all things considered” [italics added] [2]. If this is true, it should be much more likely to be morally permissible for adult women to make such decisions for themselves.

**The relational well-being**

Consider the case where an infibulated woman ends up with a partner (or a husband) to whom she feels emotionally and (second-order) autonomously strongly attached. Regardless of whether the woman’s choice to get into this relationship was initially autonomous, a deep, well-functioning, lasting and happy pair bond may develop over time as the partners share experiences and emotions. In such a pair bond the woman is actually involved autonomously. It is in her best interest this *already established* relationship to be continued. Between the woman and her partner (or husband) may has been established an authentic, affective and interactive relationship that over time may shift far beyond sexuality. However, sexuality (e.g. sexual pleasure of the woman’s partner) may be instrumental in fostering the well-functioning happy relationship, all things considered. In this context, being the woman infibulated may be in all likelihood instrumental in enhancing the sexual pleasure of her male counterpart, all else being equal. Besides, because of deeply held cultural convictions the partners, the symbolic values that both place on female genitals may be significant part of the values that underpin their pair bond. The vast majority of Somali women living in UK choose to undergo intrapartum deinfibulation in the belief that such an opening is her husband’s business only [18]. Prohibition of reinfibulation might be grossly disproportionate intervention of the state insofar as reinfibulation is instrumental, all else being equal, in maintaining the *already existing* and *valuable for all cultures* status of woman’s relational well-being. From a moral point of view, there is a considerable difference between posing a threat to an *already existing situation* and hopes for a future one. Besides, it is to be noted that happy pair relations are in the strict sense healthy [22].

**The subjective/psychological well-being**

A woman may develop over time an empowered and well-established *already existing* relationship with her own infibulated genitals (herself) especially if underwent infibulation in childhood. Genitals represent a most particular and valuable part of a human body which holds considerable symbolic value. The symbolic value that a woman places on her genitals is greatly influenced by environmental factors that reflect the values of her own culture of origin to which she is attached. According to phenomenologists [23], the higher the symbolic value of a part of the human body the more likely that it assumes greater internal “visibility” and therefore plays an important role in the way that one perceives oneself.

Moreover, if the constructive theories of gender identity are true, the woman’s sense of femininity results from interaction between biological body (as essentialism argues) and social body (as constructivism argues) [24].

Furthermore, defibulation does not restore emotional normality. It may cause a woman to feel embarrassed about her body and experience unpleasant sensations arising from the edges of the incision (perhaps due to free nerve endings cutting). Deinfibulated women reported feeling “openness” and embarrassment about some bodily functions (e.g. urination) related to genitals. Besides, they are reported feeling “naked” and “ugly” as if they have a “cow pussy” or a masculine-type protrusion [2,7,25-27]. The anthropologist Gruenbaum states that “women conceive of the uninfibulated body as lacking in both propriety and beauty, as well as making a woman less able to please a husband sexually” [28]. Deinfibulation may cause low sense of self-worth. On the other hand, infibulated women who are attached to the values of their culture of origin when considering the “normalcy” of their body (genitals) describe themselves as “neat”, “smooth”, “clean”, “virgin” and having child-type genitals [2,7,25-27,29]. Notwithstanding, a migrant woman’s positive attitude towards values of her culture of origin can be changed when a “critical mass” of the population of her community abandon the infibulations [30] or she assume a positive attitude towards values of in the host country (“acculturation”). Therefore, she may feel like she has lost something important [2], thus resulting in “mental/psychological infibulation” [3].

Moreover, it is stated that, deinfibulation and delivery may constitute repetition of women’s traumatic experience of infibulations [31].

**The sexuality**

The assumption that infibulation eliminates the female sexuality is one of the western-type false perceptions towards NTFGC/A. Infibulation does not always eliminate the woman’s capability for having sexual desire, arousal, pleasure and even achieving orgasm [2,3,25-27,29]. Besides, it is doubtful whether deinfibulation can enhance the existing sexuality (for reasons mentioned below) of a certain woman or even reduce it (for reasons mentioned above).

It is important that in many cases of infibulation clitoris remains intact (because of the fear of bleeding) or partially cut (having lost the “tip of the iceberg”) under the scar [2, 27]. Even after the external part of clitoris has been removed the woman may maintain her capability for achieving orgasm. Clitoral tissue and its abundant sensory nerve endings are well-embedded in vulva pervading it and arriving beneath the surface, thus blurring the distinction between clitoral and vaginal orgasm [2, 7, 27]. Moreover, erogenous tissues may be enhanced to compensate for the absent (partially or totally) clitoris [27].

Furthermore, sexuality is a highly (if not entirely) subjective issue [2]. The scientific assessment of sexuality [25-27, 31] as well as the overemphasized role attributed to genitals in reaching sexual satisfaction (“genital determinism”) [31] is reliably argued to be oversimplification. Sexuality is a multi-dimensional and complicated issue which is mentioned in the literature as interaction between mental process, relational dynamics, neurophysiological and biochemical mechanisms. These factors may interact between them and be profoundly affected by other psycho-biological and/or socio-cultural factors (perhaps overlapping) [3, 29].

The sexuality of a woman is argued to be strongly or entirely determined by culture[2, 3, 31]. In any case, environmental factors that reflect cultural values strongly affect the way a woman enacts her sexuality, the value that a woman places on her genitals, the meaning that she attributes to her sexual experiences as well as her own concept of the good.

A (Western-centric) study of African communities in the EU showed “the contradictory nature of women’s sexual experiences” [32]. In the literature the brain is said to be the most important female sexual organ [33]. Besides, a fulfilling pair relation full of tenderness and affection in the context of which the husband holds his wife dear and devotes plenty time to making love may determine the woman’s sexual pleasure and satisfaction [3]. As mentioned above, the fact that the woman is infibulated may be instrumental to developing such a pair relation, all else being equal.

In the interesting study of Florence infibulated women reported “vivid” orgasm though it is not clear whether an infibulated woman perceive the accurate meaning of orgasm [2]or if there is sexual pleasure without orgasm [3].

**AYTONOMY AND REINFIBULATION: A RELATIONAL AUTONOMY BASED VIEW**

**Relational autonomy is a true autonomy**

Autonomy is a variously conceived concept. There are several accounts of autonomy between of which there is not any evidence of superiority. Multiple perspectives about the nature of autonomy have been represented in literature. In a world of interdependence and human vulnerability the notion of autonomy is better advanced in relational terms, thus involving emphasizing ‘the social nature of the self and the social relations and conditions that are necessary for the realization of autonomy’ (McKenzie, Stoljar 2000). A completely individualistic account of autonomy is an “illusion”. (Nedelsky 2011). Self-sufficient or ‘self-made’ person (Veltman and Piper 2014) is an illusion. Not only in light of Kantian approach of autonomy but also according to purely proceduralist accounts of autonomy agent’s reflection is suitably independent. However, in a world where individuals are embedded in a interactive and inter-relational complex net of dependence, intra-dependence, care and duties, self can only be conceptualized as relational self. Relational theories of autonomy explore how internalized oppression and oppressive social conditions undermine or erode agents' capacity for autonomy to the point that invalidate autonomy and prevent agents from making autonomous choices. In light of relational autonomy there are connections between autonomy and other aspects of the agent, including self-conception, self-trust, self-acceptance and self-worth. In a relational analysis of autonomy it is argued that autonomy is a multidimensional and context-sensitive con­cept, ‘with three distinct but causally interdependent axes: self-determination, self-governance, and self-authorization (Veltman and Piper 2014). Self-authorization is conceptualized as an individual’s *normative authority* to be self-determining and self-governing with re­spect to their motivational structure, to endorse their desires resulted from self-reflection (Veltman and Piper 2014).

**The autonomous desire for reinfibulation**

An autonomous request for reinfibulation should meet the following requirements:

1. A valid informed consent process should be established. It should be evaluated by a psychiatrist. The woman should receive clear, concise and unbiased information. Besides, her physician should go beyond information and help refibulation seeking women to insight their situation and be engaged in their decision-making process with their values, preferences and emotions so that their choice to be in reality valid.
2. If maladaptation to the changes in the body post deinfibulation is intended by the psychiatrist the operant reason for requesting reinfibulation. The request for reinfibulation seems (at first blush) to be an irrational request. However, it can be reflectively endorsed by the woman. Maladaptation to the changes in the body post deinfibulation may be viewed as medical reason in the strict (traditional) sense of the term, from both an objective and subjective standpoint.
3. If external pressure (social and cultural oppression) is the operant reason for requesting infibulation, this does not automatically deprive the woman of the ability to autonomously request reinfibulation. External oppression invalidates an agent’s autonomy if and only if it goes beyond a certain point. Below I explore what requirments have to be met for a request for reinfibulation to be judged autonomous when external pressure is the operant reason for requesting infibulations.

An expression of cultural-based discrimination (perhaps cultural imperialism) towards non western-type cultures is the assumption that women is no way capable of making choice to undergo infibulation (a non western-type choice) [29]. In first blush, it is seems to be a reasonable assumption to make. Uninfibulated women are strongly threatened by stigma, ostracism, sexual and social rejection [2]. In their communities decision-making process is “complex” and “dynamic” [28]. Women are said to be faced with strong pressures by her family or their cultural/social environment in coming to their decision on reinfibulation, though it is not a well-established association [29]. Prevalence estimates for infibulation range from 10% to 15% [29].

Nevertheless, any coercion does not deprive a woman of the ability to make autonomous choices. Indeed, in our everyday life we do not make choices in a vacuum having limitless options. To avoid a nihilistic constructivism we make some “autonomous” choices that however are profoundly influenced by both external coercions or internal compulsions (or fallibilities). Thus, they fall short of ideal autonomy. For instance, there are (sometimes strong) environmental influences regarding lifestyle, fashion, beautification, dieting, tattooing, accepted medical treatment, hymen reconstruction surgery, breast implantation or cosmetic genital surgery (western-type NTFGC/A) [34]. There are similarities between cosmetic genital surgery (as well as breast implantation surgery)and some other forms of NTFGC/A practices that involve autonomous choice of the woman [35]. Some forms of the so-called “cosmetic” genital surgery may be anatomically indistinguishable from other forms of NTFGC/ practices. In both cases the choice of the woman may be shaped by cultural or social factors. It is stated that 30-50% of women with genital piercing reported abuse or forced sexual assault against their will [35]. There is “patriarchy” of the “beauty industry” [36].Therefore, under strong universalism should both be practices of either permitting or banning. If not, a double standard has been applied (culture-based or even based on professional interests). As Johnsdotter and Essenstate, “even the pricking of the African clitoral hood is condemned, while reduction of the clitoral tissue in a European woman is legal and accepted” [37].

Besides, there are “fallibilities” of our internal processes, as: motivated reasoning, (intuitive-based) reason-bypassing biases, emotional pressure on reasoning, impulsions, impaired judgment, internalization of external oppressions and even commitment to “irrational” beliefs [38] (perhaps related to one’s culture or religion).

In my opinion, it is of crucial importance what conditions ordinarily should thought to be requirements for autonomous choices. In fact, what choice would be *considered* to be autonomous may be a matter of autonomy *thickness* (height of standards). With regard to the particular topic of this discussion, autonomy should meet no less than some minimum standards. Its thickness should be proportional to what (bodily injury) justifies.

By analogy with a medical treatment that is instrumental to preserving health (in the strict sense), reinfibulation may under certain circumstances be instrumental to fostering the woman’s status of health (broadly understood) and well-being, and as such be a “medical treatment” (broadly understood). If *thin* autonomy (informed critical reflection) can justify a severe bodily injury as part of a medical treatment (strictly understood), *thick enough* (if not *full thick*) autonomy can justify a broadly understood “medical treatment” (*mutatis mutandis*).

Although not as thick as the autonomy of a sex-change seeker (striving against his/her family and social context), the *thick enough* autonomy of a woman might justify her undergoing reinfibulation. In my opinion, it can be ascertained when the following minimum standards of thick autonomy are met:

a) Smooth-functioning mechanisms and skills of autonomy such as: critical reflection (so that even seemingly irrational decisions, e.g. to undergo reinfibulation, may be reflectively endorsed), self-trust/regard/worth/esteem/confidence, and normative consciousness [39]. However, these mechanisms and skills may be most likely to be eroded by social and cultural oppressions. A deinfibulated woman may face pressures by midwives, family or female relatives [6]. However, there is no definitive answer to whether a particular external pressure is coercive to the point that invalidates or compromizes consent. A key determinant factor is whether it is about a strong-willed woman, namely, able to do otherwise. Uninfibulated women may display low self-competence and self-esteem insofar as they feel to be unable to satisfy their husbands sexually. Besides, they may display low self-esteem for other reasons anticipated above.

b) “Open door” for the woman to exit an oppressive context. It should be established that no considerable external obstacles (physical or psychological) are standing in the way of opting to stay deinfibulated. This implicates that there is thick autonomy.

c) Adequate information. Many women seeking reinfibulation are inadequately informed or not included in the decision-making process, and

d) Congruence between second-order autonomy and first-order autonomy regarding reinfibulation.

“Second-order” autonomous person is one who forms, revises and pursues her own life on her own values, beliefs, motives, goals and desires being free from external influences or internal coercions. First-order autonomous is one who considers and endorses or rejects the rules that determine the way of one’s life [34]. When there is *full thick* (“ideal”) second-order autonomous choice that does not poses high and severe risk of (especially other-regarding) harm, it would be consistent for a politically liberal state to refrain from intervening. Under political liberalism (ideal) second-order autonomy encompasses alienating of first-order autonomy (self-abrogation) [34]. However, this is not the case with the here so-called “*thick enough*” second-order autonomy. Reinfibulation is not what women really want when autonomously concluding that “cultural tradition or cohesion or getting married and bearing children are more important than bodily integrity” [40].

In short, I am in line with the opinion that a woman can autonomously decide to undergo reinfibulation [34, 41-43]. Furthermore, I attempt to specify her autonomy at a more precise level.

**SYMBOLIC HARM**

At first blush, reinfibulation is other-regarding symbolic harmful practice insofar as it perpetuates female submission, male domination, gender inequity, discrimination and encourages other women to seek to undergo infibulation. However, reinfibulation may cause only insignificant (if any) other-regarding symbolic harm, so that intolerance for reinfibulation (intervention of the state) would be grossly disproportionate from even a point of view of liberal perfectionism. As Galeotti argues, tolerance of a practice is not always recognition of it [43]. The overarching goal of a here considered permissible reinfibulation is to preserve the woman’s already existing health/well-being status. In contrary, the overarching goal of infibulation is to cause the woman’s body to become valuable in her culture and society. Tolerance for infibulation is recognition of the values of the foreign culture. Besides, a request for reinfibulation will be judged individually.

It is reasonably argued that a consensual and hygienic minimal and symbolic procedure (a cut with a tiny bloodletting) with no permanent damages or risks is permissible [43]. If such a procedure that is minimally *harmful* (the cut of nerve endings in clitoral hood is negligible damage) do not cause other-regarding symbolic harm, this would also be the case with a consensual *health* *beneficial* reinfibulation.

**CONCLUSION**

It is possible for reinfibulation to be inter-culturally beneficial to woman’s health (broadly understood) and well-being. Benefits may outweigh the harms and risks of reinfibulation. Whether this is the case is determined by a large range of determining factors regarding her subjective and relational well-being both *ante* and *post* deinfibulation. The individual assessment of them is a difficult task requiring personal communication between physician and patient. Besides, there should be a proportional relationship between the possible harms or risks and benefits of reinfibulation under the individual circumstances. I stress the crucial role of virtue ethics (integrated into principlism), especially of practical wisdom (= *phronesis*), in making sensitive and difficult assessments regarding each individual case.

Besides, I raise the point that a request for reinfibulation which is expected to be proportionally beneficial to the total health/well-being status of a woman should be justified by her *thick enough* autonomy. Thick enough autonomy can be ascertained when the woman’s *mechanisms and skills* of autonomy are well-functioning, she has an “*open exit*” to leave the oppression, there is *congruence between first and second-order autonomous* woman’s choice to undergo reinfibulation and *adequate information* has been provided. Further, physician should go beyond information and help refibulation seeking women to insight their situation and be engaged in their decision-making process with their values, preferences and emotions. It should be highlighted that if maladaptation to the changes in the body post deinfibulation are intended by the psychiatrist as the operant reason for requesting reinfibulation, reinfibulation should be considered ethically acceptable, regardless of the thickness of autonomy.

Under the here presented assumption there is no other-regarding symbolic harm of reinfibulation. Besides, medicalization of reinfibulation may deter clandestine reinfibulations.

## Declarations

## Abbreviations: NTFGC/A= Non Therapeutic Female Genital Cutting/Alteration

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### Authors’ contributions

P. Voultsos is the only author of the manuscript.

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**References**

1. World Health Organization. Eliminating female genital mutilation. An interagency statement. Geneva: WHO, 2008.

2. Earp BD. Between moral relativism and moral hypocrisy: Reframing the debate on “FGM.” Kennedy Institute of Ethics Journal 2016; 26(2):105-44.

3. Catania L, Abdulcadir O, Puppo V, [Verde JB](https://www.ncbi.nlm.nih.gov/pubmed/?term=Verde%20JB%5BAuthor%5D&cauthor=true&cauthor_uid=17970975), [Abdulcadir J](https://www.ncbi.nlm.nih.gov/pubmed/?term=Abdulcadir%20J%5BAuthor%5D&cauthor=true&cauthor_uid=17970975), [Abdulcadir D](https://www.ncbi.nlm.nih.gov/pubmed/?term=Abdulcadir%20D%5BAuthor%5D&cauthor=true&cauthor_uid=17970975). Pleasure and orgasm in women with female genital mutilation/cutting (FGM/C). The Journal of Sexual Medicine 2007; 4(6): 1666-78.

4. Leye E, Ysebaert I, Deblonde J, [Claeys P](https://www.ncbi.nlm.nih.gov/pubmed/?term=Claeys%20P%5BAuthor%5D&cauthor=true&cauthor_uid=18465481), [Vermeulen G](https://www.ncbi.nlm.nih.gov/pubmed/?term=Vermeulen%20G%5BAuthor%5D&cauthor=true&cauthor_uid=18465481), [Jacquemyn Y](https://www.ncbi.nlm.nih.gov/pubmed/?term=Jacquemyn%20Y%5BAuthor%5D&cauthor=true&cauthor_uid=18465481), et al. Female genital mutilation: Knowledge attitudes and practices of Flemish gynaecologists. The European Journal of Contraception and Reproductive Health Care 2008; 13(2):182-90.

5. Toubia N. Female Circumcision as a Public Health Issue. The N Engl J Med 1994; 331 (11): 712-6.

6. Serour GI. The issue of reinfibulation. International Journal of Gynaecology and Obstetrics 2010; 109(2): 93-6.

7. Shweder RA. The goose and the gander: The genital wars. Global Discourse 2013; 3(2): 348-66.

8. Davis DS. Male and female genital alteration: A collision course with the law? Health Matrix 2001; 11: 487-687.

9. Arora KS, Jacobs AJ. [Female genital alteration: a compromise solution.](http://www.ncbi.nlm.nih.gov/pubmed/26902479) J Med Ethics. 2016;42(3):148-54.

10. Shahvisi A. Cutting slack and cutting corners: an ethical and pragmatic response to Arora and Jacobs’‘Female genital alteration: a compromise solution’. Journal of medical ethics 2016; 42(3):156-7.

11. Macklin R. Not all cultural traditions deserve respect. Journal of medical ethics 2016; 42(3): 155.

12. Earp BD. In defence of genital autonomy for children. Journal of Medical Ethics 2016b; 41(3): 158-63.

13. DeLaet DL. Framing male circumcision as a human rights issue? Contributions to the debate over the universality of human rights. Journal of Human Rights 2009; 8(4): 405-26.

14. Johnson M. Male genital mutilation: Beyond the tolerable? Ethnicities 2010; 10(2): 181-207.

15. Svoboda JS, Adler PW, Van Howe RS. [Circumcision Is Unethical and Unlawful.](http://www.ncbi.nlm.nih.gov/pubmed/27338602) J Law Med Ethics. 2016;44(2):263-82.

16. Frisch M, Earp BD. Circumcision of male infants and children as a public health measure in developed countries: A critical assessment of recent evidence. Global Public Health, 2016, in press.

<http://www.tandfonline.com/doi/full/10.1080/17441692.2016.1184292> (accessed: 15 July 2016)

17. Johnsdotter S, Essén B. [Cultural change after migration: Circumcision of girls in Western migrant communities.](http://www.ncbi.nlm.nih.gov/pubmed/26644059) Best Pract Res Clin Obstet Gynaecol. 2015 Oct 24. pii: S1521-6934(15)00195-9.

18. Moxey JM, Jones LL. [A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England.](http://www.ncbi.nlm.nih.gov/pubmed/26743705) BMJ Open., 2016; 6(1):e009846. doi: 10.1136/bmjopen-2015-009846

19. Knipscheer J, Vloeberghs E, van der Kwaak A, van den Muijsenbergh M. [Mental health problems associated with female genital mutilation.](http://www.ncbi.nlm.nih.gov/pubmed/26755984) BJPsych Bull. 2015;39(6):273-7.

20. [Creighton SM](http://www.ncbi.nlm.nih.gov/pubmed/?term=Creighton%20SM%5BAuthor%5D&cauthor=true&cauthor_uid=25791840), [Hodes D](http://www.ncbi.nlm.nih.gov/pubmed/?term=Hodes%20D%5BAuthor%5D&cauthor=true&cauthor_uid=25791840). Female genital mutilation: what every paediatrician should know. [Arch Dis Child.](http://www.ncbi.nlm.nih.gov/pubmed/25791840) 2016;101(3):267-71

21. Richman KA. Ethics and the Metaphysics of Medicine. Reflections on Health and Beneficence. Cambridge, MA: The MIT Press, 2004.

22. Savulescu J, Sandberg A. Neuroenhancement of love and marriage: The chemicals between us. Neuroethics 2008;1(1):31–44.

23. Svenaeus F. [Organ transplantation and personal identity: how does loss and change of organs affect the self?](http://www.ncbi.nlm.nih.gov/pubmed/22474141) J Med Philos. 2012;37(2):139-58.

24. Elson J, Hormonal Hierarchy. Hysterectomy and Stratified Stigma. Gender & Society 2003; 17(5): 750-70.

25. Obermeyer C. The consequences of female circumcision for health and sexuality: an update on the evidence. Culture, Health & Sexuality 2005;7(5): 443-61.

26. Obermeyer CM. The health consequences of female circumcision: science, advocacy, and standards of evidence. Medical anthropology quarterly 2003; 17(3): 394-412.

27. Obermeyer CM. Female genital surgeries: The known, the unknown, and the unknowable. Medical anthropology quarterly 1999; 13(1): 79-106.

28. Gruenbaum E. [The cultural debate over female circumcision: the Sudanese are arguing this one out for themselves.](http://www.ncbi.nlm.nih.gov/pubmed/8979232) Med Anthropol Q. 1996;10(4):455-75.

29. Abdulcadir J, Ahmadu FS, Catania L, [Essen B](https://www.ncbi.nlm.nih.gov/pubmed/?term=Essen%20B), [Gruenbaum E](https://www.ncbi.nlm.nih.gov/pubmed/?term=Gruenbaum%20E), [Johnsdotter S](https://www.ncbi.nlm.nih.gov/pubmed/?term=Johnsdotter%20S), et al. Seven things to know about female genital surgeries in Africa. The Hastings Center Report 2012; 42(6): 19-27.

30. Mackie G, LeJeune J. Social dynamics of abandonment of harmful practices: a new look at the theory. Special Series on Social Norms and Harmful Practices, Innocentim Working Paper No. 2009-06, UNICED Innocenti Research Centre, Florence, 2009.

31. Johnsdotter S. Discourses on sexual pleasure after genital modifications: the fallacy of genital determinism (a response to J. Steven Svoboda). Global Discourse 2013; 3(2): 256-65.

32. Brown K, Beecham D, Barrett H. The Applicability of Behaviour Change in Intervention Programmes Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches. Obstetrics and Gynecology International Article ID 324362, 12 pages, 2013. doi:10.1155/ 2013/324362

33. Heiman JR. Orgasmic disorders in women. In: Leiblum SR, ed. Principles and Practice of Sex Therapy. New York: Guilford, 2007: 84

34. Chambers C. Are breast implants better than female genital mutilation? Autonomy, gender equality and Nussbaum's political liberalism. Critical Review of International Social and Political Philosophy 2004; 7(3): 1-33.

35. Nelius T, Armstrong ML, Rinard K, [Young C](https://www.ncbi.nlm.nih.gov/pubmed/?term=Young%20C%5BAuthor%5D&cauthor=true&cauthor_uid=22054364), [Hogan L](https://www.ncbi.nlm.nih.gov/pubmed/?term=Hogan%20L%5BAuthor%5D&cauthor=true&cauthor_uid=22054364), [Angel E](https://www.ncbi.nlm.nih.gov/pubmed/?term=Angel%20E%5BAuthor%5D&cauthor=true&cauthor_uid=22054364). Genital piercings: diagnostic and therapeutic implications for Urologists. Urology 2011;78:998–1008.

36. Johnsdotter S, Essen B. Genitals and ethnicity: the politics of genital modifications, Reproductive Health Matters 2010; 18(35): 29-37.

37. Johnsdotter S, Essen B. Genitals and ethnicity: the politics of genital modifications, Reproductive Health Matters 2010; 18(35): 29-37.

38. Savulescu J, Momeyer RW. [Should informed consent be based on rational beliefs?](http://www.ncbi.nlm.nih.gov/pubmed/9358347) J Med Ethics 1997;23(5):282-8

39. Stanford Encyclopedia of Philosophy. Feminist Perspectives on Autonomy. (First published Thu May 2, 2013). Available from: <http://plato.stanford.edu/entries/feminism-autonomy/> (accessed: 15 July 2016).

40. Meyers DT. Feminism and Women's Autonomy: The Challenge of Female Genital Cutting, Metaphilosophy, 2000a; 31: 469–91.

41. Dustin M. Female Genital Mutilation/Cutting in the UK Challenging the Inconsistencies. European Journal of Women's Studies 2010; 17(1): 7-23.

42. Mason C. Exorcising excision: medico-legal issues arising from male and female genital surgery in Australia. Journal of Law and Medicine 2001; 9(1): 58-67.

43. Galeotti A. E. Relativism, universalism, and applied ethics: the case of female circumcision. Constellations 2007;14(1):91-111.

**ADDITIONAL REFERENCES LIST:**

MacKenzie C. and Stoljar N., eds., Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self. New York: Oxford University Press. 2000. pp: 4.

Nedelsky J. Law’s Relations: A Relational Theory of Self, Autonomy, and Law. New York: Oxford University Press. 2011.

Veltman A., Piper M. (ed.) Autonomy, Oppression and Gender. New York: Oxford University Press. 2014. pp: 15-41.

Benson P. “Feminist Intuitions and the Normative Substance of Autonomy,” in *Personal Autonomy*, edited by James Stacey Taylor (Cambridge, UK: Cambridge University Press, 2005), 128–130, 136.

Westlund, A. Rethinking Relational Autonomy. *Hypatia* 2009; 24: 26–49.

Christman, J. Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves. Philosophical Studies 2004; 117: 143–164.

[Bello S](https://www.ncbi.nlm.nih.gov/pubmed/?term=Bello%20S%5BAuthor%5D&cauthor=true&cauthor_uid=28164284), [Ogugbue M](https://www.ncbi.nlm.nih.gov/pubmed/?term=Ogugbue%20M%5BAuthor%5D&cauthor=true&cauthor_uid=28164284), [Chibuzor M](https://www.ncbi.nlm.nih.gov/pubmed/?term=Chibuzor%20M%5BAuthor%5D&cauthor=true&cauthor_uid=28164284), [Okomo U](https://www.ncbi.nlm.nih.gov/pubmed/?term=Okomo%20U%5BAuthor%5D&cauthor=true&cauthor_uid=28164284), [Meremikwu MM](https://www.ncbi.nlm.nih.gov/pubmed/?term=Meremikwu%20MM%5BAuthor%5D&cauthor=true&cauthor_uid=28164284)**.** Counselling for deinfibulation among women with type III female genital mutilation: A systematic review. [*Int J Gynaecol Obstet*.](https://www.ncbi.nlm.nih.gov/pubmed/28164284) 2017;136 Suppl 1:47-50.

Vrachnis N, Salakos N, Iavazzo C, *et al*. Female genital mutilation in Greece. *Clin Exp Obstet Gynecol* 2012; 39(3): 346-50.

Tian Y, Liu W, Wang JZ, Wazir R, Yue X, Wang KJ. [Effects of circumcision on male sexual functions: a systematic review and meta-analysis.](https://www.ncbi.nlm.nih.gov/pubmed/23749001) Asian J Androl. 2013 Sep;15(5):662-6.