Exorcising Excision: Medico-Legal Issues Arising From Male and Female Genital Surgery in Australia

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Genital surgery is one of the most controversial and contested practices, yet it is frequently described and referred to with little or no attention to cultural and social context. This article examines the practice, performed on both men and women, and the extent to which it clashes with issues of consent and capacity, as well as multicultural concepts of toleration for minority group practices. It then questions why female genital surgery, unlike male genital surgery, is legally prohibited in Australia. It argues that such legal gender bias stems from a liberal conception of “tolerance” and the limits of consent in Australia, placing female genital surgery in an “unacceptable” category and male genital surgery in an “acceptable” category.

Introduction

The issue of genital surgery has sparked heated debate in Australia,1 and while this article does not condone it or deny its deleterious effects, it does attempt to situate it within a cultural context. It is a practice performed on both men and women to different extents and for a variety of reasons: religious, cultural, political, sexual and health-related. It is an act that is controversial for both the law and the medical establishment to deal with since it clashes, at times, with issues of consent and capacity as well as challenging the extent of multicultural concepts of toleration for minority group practices.2 Most controversially, female genital surgery is legally prohibited yet male surgery is not – despite heavy criticism of the latter.3 This article argues that such legal gender bias stems from a liberal conception of “tolerance” and the limits of consent in Australia. Thus, female genital surgery is not viewed as an “acceptable” minority practice but male genital surgery is. This article reaches this conclusion by first examining the practice of female genital surgery and then assessing its legal ramifications in Australia. This is followed by a similar survey of male genital surgery and a final section which assesses the divergent status accorded to each in Australian law and society.

Female genital surgery

Definitional debates

Female genital surgery is heavily criticised4 and

4 Key critics include F P Hosken, The Hosken Report: Genital and Sexual Mutilation of Females (4th ed, Women’s International Network, Lexington, 1993); N Toubia,
most commonly referred to as “female genital mutilation” (FGM). For example, the World Health Organisation (WHO) formerly referred to the practice as “female circumcision” but changed this to “female genital mutilation” at its 1990 Addis Ababa Conference. The altered terminology was said to carry “heavier moral weight.”

As described by the Egyptian women’s activist and doctor, Nawal El Saadawi, female genital surgery, varyi ng

Amongst the Chamus of Kenya the initiation process, involving clitoridectomy, is still practised as an integral part of contemporary Chamus culture. Kawai found that “[t]he ordeal is a source of invaluable pride to the girl. Elderly women still take pride in their brave attitude many years before.”

Secondly, without denying the adverse effects of female genital surgery, it is important to recognise that the term “mutilation” stems from a neo-colonial narrative that views genital surgery, and the people

### Female Genital Mutilation: A Call for Global Action (2nd ed, RAINBO, New York, 1995).


7 Author’s interview, Khadija, Asmara, Eritrea, 22 October 1999.


11 Davis, op cit n 5, at 145.

12 Robertson’s research on the Kikuyu peoples of Kenya found exactly this. Genital surgery, varying from minor cuts to clitoridectomy, was central to female initiation. This initiation into adult life led to the reception of knowledge and wisdom from respected elders and entailed special treatment of girls during the initiation period. Girls entered into a realm of power separate from men and forged intense solidarity both as a group and also between the initiated girl and the female elder who “held” her during the ceremony. Girls were imbued with a sense of “triumph” and “empowerment” that stayed with them for life. The practice gradually faded out among this particular group due to collective female labour action that evolved into new forms of women’s groups, leading to the decline in initiation ceremonies and associated genital surgery. Amongst the Chamus of Kenya the initiation process, involving clitoridectomy, is still practised as an integral part of contemporary Chamus culture. Kawai found that “[t]he ordeal is a source of invaluable pride to the girl. Elderly women still take pride in their brave attitude many years before.”

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Secondly, without denying the adverse effects of female genital surgery, it is important to recognise that the term “mutilation” stems from a neo-colonial narrative that views genital surgery, and the people
involved with it, as “barbaric and uncivilised”. The following statements are apt in this regard:

“[F]emale circumcision is a totally heinous thing. It is impossible to find a single circumstance in which such a barbaric procedure could be justified in a civilised society such as ours.”

“The primitive attitude to female circumcision rests not only on tradition, but also on the male desire for the female to be pure for him… That is not only the most cruel, but also the most primitive, and the most important aspect of the matter we should reject.”

This approach is not grounded in the lived experiences of many women, and although often benevolent, it creates an artificial and hierarchical division between “us” (Western, civilised) and “them” (primitive, barbaric). Such divisions do nothing to alter existing cultural tensions and misunderstandings and stifle useful and constructive cross-cultural dialogue. As Gunning pointed out:

“[T]he ‘us helping them’ approach has created an enormous amount of bitterness in non-Western feminists for whom the attitude is chillingly reminiscent of colonialism.”

Thirdly, the “FGM” label does not do justice to the many varieties of genital surgery, that range from minor ritual acts to severe infibulations. “FGM” is a broad “cover all” that attempts to narrowly define and sensationalise the practice. In order to explain its complexity, the next section examines the varieties of female genital surgery.

The practice

Female genital surgery is practised predominantly in parts of Africa, the Middle East and Asia. It is frequently linked to religion, though it predated Judaism, Christianity and Islam, and is also practised among some animist groups. Islam is the only religion which stipulates any limited grounding for the practice. According to Abu-Sahlieh, this comes from a several sources including a hadith relating to a conversation between the Prophet Mohammed and an exciser, Um Habibah, after she emigrated with him to Medina. Upon asking her if she still continued the art, she replied that she did unless he forbade it. The Prophet said to her:

“Cut slightly and do not over-do it [ash-immi wa-la tanhaki] because it is more pleasant [ahza] for the woman and better [ahab] for the husband.”

However, in terms of Islamic jurisprudence, this source (and several others also invoked) are of questionable authority and weight. Most Muslims choose not to practise genital surgery and many who do, do so incorrectly in the belief that it is written in the Qur’an. As illiteracy is prevalent in many regions where genital surgery is performed, neither women nor men have access to the Qur’an themselves. Female genital surgery is therefore a predominantly traditional cultural practice – existing in areas where religion spread and was grafted onto old traditional practices. It is practised for multivariable reasons: to ensure cleanliness and hygiene, to control female sexual urges and prostitution, to indicate initiation into adulthood, to express religious faith, to ensure virginity upon marriage, and to guarantee chastity in a husband’s absence.

Four main categories of genital surgery exist:

1. ritualised genital surgery is the least severe and can amount to as little as a symbolic act of cleaning the clitoris; at other times the clitoris is scraped or nicked.
2. The second and intermediate form is commonly termed sunna (tradition) and involves the removal of the clitoral hood and at times the glands of the clitoris.
3. The third is excision and usually involves removing the whole clitoris.
4. The fourth and most severe is infibulation or “Pharaonic” genital surgery. This involves removing all of the external female genitalia and sewing the remaining edges together with a small passage for menstruation and urination.

16 Ibid at 325 (emphasis added).
19 The author thanks Jamila Hussain, Lecturer in Law, University of Technology Sydney, for her useful comments in this regard. See also J Hussain, Islamic Law and Society (Federation Press, Sydney, 1999), p 132.
As a practice in Africa, it is predominantly performed by a midwife in unsanitary conditions and with implements varying from knives to sharp rocks and glass. However, in some circumstances, as in Somalia and Egypt, health professionals have been known to perform the procedure in clinics.\(^{20}\)

The impact of female genital surgery has been increasingly documented. A recent Australian study of complications relating to genital surgery highlighted dyspareunia, aparenia, dysmenorrhoea, urinary tract and vaginal infections and labour difficulties.\(^{21}\) Other studies point to the possibly extensive psychological damages caused by the practice, though this is less adequately documented. At the same time, whilst it can eliminate sexual feeling and pleasure (and make intercourse agonising or impossible), other studies have shown that this is not uniform: “an unpredictable response from women who cannot, at least according to Western medical discourse, enjoy the act.”\(^{22}\)

A study by Lightfoot-Klein of infibulated women in the Sudan found:

“[C]lose to 90% of women (by their own report) were orgasmic, ranging from always to occasionally and from intense to mild. Many were able to give vivid and convincing descriptions of their orgasms and to credibly ascribe frequency of occurrence.”\(^{23}\)

A 1985 Egyptian study found that 25 per cent of infibulated women could still attain orgasm through stimulation to the clitoral area, as opposed to 50 per cent of women who had not had genital surgery.\(^{24}\)

The extent of sexual damage is therefore extremely difficult to assess and is widely debated.

The age of genital surgery varies from newborn girls (as with nomads in Sudan) to seven-year-old girls (Egypt) or to those prior to menstruation. In Tanzania and Kenya, clitoridectomies are performed amongst some groups on a woman’s wedding night. Other groups, such as the Ibo in Nigeria, perform surgery prior to marriage. Another Nigerian community, the Aboh, do the same before the birth of a woman’s first child.\(^{25}\)

All these variations – in geographical locations, reasons for the procedure, the type of procedure performed and age – exemplify the global complexity of female genital surgery. Accordingly, we need to bear this in mind when examining the situation in Australia, since essentialising and stereotyping the procedure is common amongst health professionals, law-makers and society.

### Female genital surgery in Australia

Australia has a growing population of immigrants from areas that practise female genital surgery.\(^{26}\) However, there are no data on the extent of the practice in Australia; nor on the number of girls taken overseas for the performance of the act. Likewise, there is only limited research on the topic in the Australian context.\(^{27}\) However, several legal issues and initiatives exist in relation to both international and domestic law and it is therefore necessary to examine each in turn.

#### International obligations

International human rights norms remain centred on individual rights. As such, it is a controversial regime that fails to consider the more community-based nature of non-Western cultures, especially those in Africa, the Middle East and Asia.\(^{28}\)

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\(^{22}\) V Kirby, “On the Cutting Edge: Feminism and Clitoridectomy” (1987) 5 Australian Feminist Studies 35 at 44.

\(^{23}\) H Lightfoot-Klein, “Pharaonic Circumcision of Females in the Sudan” (1983) 2 Medical Law 353 at 357.


\(^{25}\) E Dorkenoo, “Combating Female Genital Mutilation: An Agenda for the Next Decade” (1999) 1 and 2 *Women’s Studies Quarterly* 89.

\(^{26}\) See Table 5, “Immigrants to Australia from Countries with a High Prevalence of Female Genital Mutilation (1985-1996)” in Knight et al, op cit n 21, at 53.


\(^{28}\) Gunning, op cit n 17, at 239; see also discussion in A Funder, “De Minimis Non Curat Lex: The Clitoris, Culture and the Law” (1993) 3 *Transnational Law and Contemporary Problems* 417.
genital surgery, though not usually specifically mentioned, appears to breach the various covenants of international organisations: the Universal Declaration of Human Rights (1948); the Convention on the Elimination of All Forms of Discrimination Against Women (1979); and the Declaration on Violence Against Women (1993).

The issue of female genital surgery has also been raised in the context of the United Nations Convention relating to the Status of Refugees and refugee applications in Australia. In 1997 the Refugee Review Tribunal recognised the threat of imminent genital surgery that a mother and her 18-month-old daughter faced if they were forced to return to Nigeria. The tribunal explained:

“[T]he female circumcision feared by the Applicant is not an operation that is tailored to her personally in the way that an operation for the excision of a melanoma or the removal of a rotten tooth is directed at an individual personally for the amelioration of a particular problem. There is nothing about female circumcision which will be beneficial or medically desirable for either the Applicant or her daughter: indeed, the opposite is true.”

As a result, the tribunal held that both mother and daughter were refugees and had a well-founded fear of persecution, that is, “female genital mutilation.” It appears that such applications may increase as awareness of the grounds for refugee applications are more widely circulated among regions practising female genital surgery.

**Legislative issues**

Some Australian States and Territories have enacted amendments to existing legislation prohibiting “female genital mutilation”, while others believe the existing Criminal Codes amply cover the issue. In New South Wales the *Crimes (Female Genital Mutilation) Amendment Act 1994* (NSW) was achieved after a long discussion process and recommendations by the Australian Family Law Council. Section 45 stipulates:

“(1) A person who:
(a) excises, infibulates or otherwise mutilates the whole or any part of the labia majora or labia minora or clitoris of another person; or
(b) aids, abets, counsels or procures a person to perform any of those acts on another person, is liable to imprisonment for seven years.”

Section 45(5), as with other comparable Acts relating to FGM, makes it clear that consent is not a defence to the charge. Distinguished from “female genital mutilation” are surgical procedures deemed necessary for the health of a person; performed during or after labour; and sexual reassignment. Other States, such as South Australia, Victoria and the Australian Capital Territory, also allow the court to make an order preventing a person from removing a child from the State; seizing the child’s passport and subjecting her to “periodic examination” to ensure surgery has not taken place. Victoria enacted similar terminology, no doubt to prevent what happened in February 1994 when an action took place between a father and the Department of Health and Community Services in the Children’s Court of Victoria. The Department was seeking care and protection orders against the father due to physical abuse. The activist group, Women Lawyers Against Female Genital Mutilation, was granted friend of the court (amicus curiae) status in this matter and obtained evidence that the abuse included infibulation of both girls. However, because infibulation took place outside Australia, the court was unable to make an order specifically addressing this abuse.

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29 Articles 3 and 5.
30 Articles 10, 12(1) and (2), 16(1).
31 Article 2(a) does specifically state that FGM constitutes violence against women.
32 Refugee Review Tribunal Reference V97/06156 (3 Nov 1997) (Tribunal member, Sue Zelinka).
33 See another case of a Somalian family that was rejected on similar grounds: Refugee Review Tribunal Reference N98/23544 and N98/23541 (7 Aug 1998) (Tribunal member, Chris Keher).
34 See also Refugee Review Tribunal Reference N98/22461 (8 Jan 1999).
36 Australian Family Law Council, op cit n 20.
37 *Children’s Protection Act 1993* (SA), s 26(1), (2), (3), (4) and (5).
38 *Crimes Act 1958* (Vic), s 33.
39 *Crimes (Amendment) Act (No 3) 1995* (ACT), s 92X(1), (2); *Crimes Act 1900* (NSW), s 92X.
The discussion processes that led to the implementation of the legislation in each State and Territory are marred by the fact that some vital opinions were omitted due to linguistic and institutional barriers. Many women originating from regions that perform genital surgery are not accustomed to discussing this issue in public or indeed in English, and some faced the additional trauma of arriving as refugees. One informant, when discussing the issue of making written submissions or discussing genital surgery for the sake of possibly enacting legislation, had this to say:

“I would never discuss this issue in public, it is not right to talk about it like that. It is a personal matter, for our women.”

Some informants originated from states with repressive political institutions where it is unacceptable to discuss family and personal issues for fear of government reprisal. Female genital surgery has been banned by certain regimes in the past, including some colonial regimes, and therefore is interpreted as part of repressive imperialism. British colonial rule in the Sudan, for example, enacted ineffective prohibition on all forms of female genital surgery in 1946. The result was not only anti-colonial rumblings under the leadership of Mahmoud Mohammad Taha but an increased urgency and reduced age for the infibulation of girls. Some of these feelings persist in Australia, and thus the imposition of change can be perceived as a type of cultural imperialism from the dominant “Anglo” majority power in Australia: an attitude of “we will ‘civilise’ you because we know and live the truth”. Thus, the Ecumenical Migration Centre argued that legislation was not appropriate for addressing the dilemma of female genital surgery in Australia, since it makes “affected women feel rejected and self-conscious – as if they had a disease.”

Despite these reservations, the legislation has been enacted but commentators emphasise that it “alone is insufficient. It should be accompanied by appropriate community-based action.” Such action is well under way in parts of Australia, but many activists are critical of the legislation:

“Does it mean a white woman can have her labia trimmed for cosmetic reasons but a Somalian Australian woman cannot because that would be female genital mutilation?”

This leads to the conundrum of the legislation making the issue a racial one. It is often assumed, if a woman is of African descent or, indeed, Muslim, that she is circumcised:

“[M]any [Western] women’s studies students may know nothing more about African women and assumed that all or most African women are genitally mutilated.”

In turn, as Mmaskepe Sejoe explained, health professionals often assume that circumcised women must be “a mindless vessel to be used and abused”. It is for this reason that many circumcised women can find the racism they experience in relation to their condition worse than the condition itself. Some therefore avoid doctors and health practitioners for fear of ridicule and embarrassment.

Additionally, such legislation means that a mother, grandmother and community “exciser” (those normally involved in female genital surgery) would face imprisonment. A girl, already injured due to the procedure, would therefore face the public uproar surrounding such a case and lose her most vital (female) support network. In short, the legislation suggests “that women who permit the operation are incompetent and abusive mothers who, in some ways, do not love their children.”
Common law: Capacity and consent

Even in the absence of legislation in, for example, Western Australia, Queensland, Tasmania and the Northern Territory, certain directives would need to be examined. Consent is the most central concept since “all medical treatment is preceded by the patient’s choice to undergo it”. Without consent, even the “least touching” (such as medical treatment) amounts to the tort of battery. Consent may be implied or express (verbally or through a consent form), but a person must have the requisite age and intelligence in order to consent to battery.

*Gillick v West Norfolk and Wisbech Area Health Service Authority* held that the rights of parents decline as a child becomes older and more competent. More crucially, Secretary, *Department of Health and Community Services v JWB and SMB* held that children, even if intellectually disabled, have the right to provide real and informed consent to medical procedures. However, if the child is incompetent and the medical treatment is non-therapeutic, then approval must be sought from the Family Court of Australia or the Supreme Court. Conversely, if the child cannot give consent, but the procedure is in the best interests of the child, parental consent is sufficient to negate actions pertaining to assault and battery. However, the majority in *Marion’s Case* identified clitoridectomy as an example of a medical treatment that is prohibited by law irrespective of parental consent.

These basic tenets raise significant problems when we analyse their impact in relation to female genital surgery. If parents consent to genital surgery and take the child to a registered medical practitioner, how does the law address this? First, the Australian Medical Association has explicitly stated that any medical practitioner found to have performed the procedure would be deregistered. Secondly, it would appear that the principle in *Marion’s Case* would apply, that is, the surgery is not, on face value, in the best interests of the child and is of no therapeutic benefit; and it seems certain that the Family Court or Supreme Court would not grant an approval for the procedure. However, the cultural significance of genital surgery is that it is a rite of passage into adulthood and in most societies where it is practised, women cannot marry if they are not circumcised. A girl who is not circumcised may be ostracised in her community in Australia and not accepted in her country of origin if she visits or returns to live or, indeed, marry. What, therefore, is in the “best” interest of the child, and by what standards are we to judge what is “best”? Regardless of these problematic moral and cultural questions, in Australia the “best interests of the child” are most certainly judged in light of Western liberal traditions. Thus, individual bodily integrity overrides cultural considerations of what a girl’s “best interest” may be. Thus, parents cannot consent to their daughter’s genital surgery and neither could a doctor perform such a procedure.

Despite the cultural tension this creates, the author agrees with this approach and feels that the legislation, despite its faults, is also right to protect minors from female genital surgery. However, a significant issue arises when differentiating between a minor and an adult. If a sound-minded adult woman (for example, prior to or, indeed, after marriage) voluntarily wants to be circumcised, perhaps in the less intrusive *sunna* form, where does she stand in respect of the law? Consent is fulfilled, so therefore, as Mackay discussed, “there must be some important difference between female circumcision and other forms of surgical operations” to differentiate it from, for example, cosmetic surgery, sexual realignment or male circumcision. How is a woman’s choice to have.

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52 *Rogers v Whitaker* (1992) 175 CLR 479 at 489.
53 As in an emergency situation, where a patient is unconscious or in a situation where a patient puts forth his or her arm to receive an injection: *O’Brien v Canard* SS Co 28 NE 266 (1891).
54 *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871.
56 (1992) 175 CLR 218 (*Marion’s Case*).
57 Ibid at 249, 263.
58 Ibid at 240.
60 Secretary, *Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 275.
her clitoral hood removed (sunna) different from a woman’s choice to have breast implant surgery or labia trimming? Consent to all three forms of surgery derives from social conceptions of how a woman’s body should appear; and all are “unnecessary” surgery that causes significant pain and scarring. Sunna genital surgery, breast surgery and labia trimming have associated risks. Breast surgery (such as enlargement, reduction, nipple alteration) can reduce overall breast and nipple sensitivity and lead to lowered self-image and sexual fulfilment. Similarly, labia trimming has been known to have associated complications and can leave women feeling physically unsatisfied with the outcome of the procedure. Therefore, as Parekh argued:

“[I]t is difficult to see in the name of what right we may tell an adult woman in full possession of her senses that her uncoerced demand for clitoridectomy is unacceptable.”

As Marion’s Case highlights, the choices of a sound-minded adult should “be respected and accepted, irrespective of what others, including doctors, may think is in the best interest of a particular person”. However, others would argue that a person cannot consent to such an act, and that although women may voluntarily wish to undergo the practice, they are not aware of the “deleterious complications” resulting from genital surgery. Or, they may be coerced by community or familial pressure. However, if a woman is acting voluntarily and is aware of the complications and risks involved, how do we differentiate genital surgery from, say, cosmetic surgery, tattooing or body piercing?

Indeed, it falls into issues surrounding the limits of consent, especially with regard to acts seen as “perverse”. The decision of the House of Lords in R v Brown indicated that consent can be a defence to certain potentially criminal acts such as surgery, male circumcision, tattooing, ear piercing and boxing. The case then considered consensual sadomasochistic activity in light of this and held by a three-to-two majority that participants could not consent to this form of harm. It appears, therefore, that the House of Lords found such behaviour “intolerable as a matter of public morality”. Female genital surgery in adult women would be likely to fall into this category – though it is yet to be challenged in the Australian courts. This is discriminatory and prejudicial and demonstrates that consent, as a concept, is determined not only by culture but, indeed, as we shall now discuss, by gender.

**Male genital surgery**

Male genital surgery has been practised in Australia as both a religious ritual of the Jewish and Muslim communities and to promote male health. Muslim communities view circumcision as compulsory for males, closely linking it to both purity and cleanliness for prayer. Male Jewish infants are circumcised seven days after birth, though this is not universally practised and has been questioned by some Jewish scholars.

Although it is not prohibited in Australia, the Australian Medical Association does not encourage the practice, and a great deal of medical opinion openly opposes it. Complications can include damage to the shaft and urethra, amputation, urethral fistulas, infection, haemorrhage, misshapen appearances, loss of sexual stimulation, problems with mother-child bonding and, extremely rarely, death. In light of such possible outcomes and the fact that there is no medical benefit, Brigman argued that male genital surgery should be included in the

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64 Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 479 at 309; see also Malette v Shalman (1990) 67 DLR (4th) 321.

65 Davis, op cit n 5, at 147.


67 [1993] 2 WLR 556.


69 Abu-Sahlieh, op cit n 18.


72 Abu-Sahlieh, op cit n 18, at 575.
definition of child abuse. Despite this, an estimated 25 per cent of infant boys are circumcised in Australia at present, and neo-natal circumcision is covered by Medicare. Unlike female genital surgery, there is no prohibition on male genital surgery in minors or adults and some commentators continue actively to encourage it.

**Issues of consent**

Again, as with the genital surgery of infant girls, consent is also at issue with infant males. In Marion’s Case, the majority excluded female clitoridectomy from the ambit of parental consent; however, Deane J referred to male genital surgery, positioning it squarely within the scope of parental consent for religious and hygienic reasons. Within this discourse, we need to understand that parental consent must be informed consent or a medical practitioner may be liable in negligence. Thus, parents must be informed of the risks associated with male genital surgery; otherwise, as with St Margaret’s Hospital of Women (Sydney) v McKibbin, an infant may be found to have been negligently circumcised.

Again, as with female genital surgery, issues of well-being, such as emotional, moral and spiritual health, are considered to be within the scope of a child’s welfare. As Haberfield explained: “a Jewish or Muslim son who is not circumcised may feel psychologically and spiritually alienated from his culture and religion.” It appears that, in the case of infant male circumcision, these more spiritual and cultural considerations trump issues of infant bodily integrity and inability to consent.

Since a child cannot be consulted and the process is painful and unnecessary at birth, such decisions should only be made by an adult male. As with adult female surgery, an adult male in full possession of his senses should be able voluntarily to elect to be circumcised. This may make sense if a man, as an adolescent or as he develops sexually, experiences some form of sexual dysfunction or discomfort due to his foreskin; or, indeed, has a psychological desire to be circumcised. In such a case, circumcision would be a medical remedy or option.

**Male and female genital surgery: Why the differences?**

The common distinction between the two practices is based on the degree of risk and harm involved. However, the sunna type of female genital surgery is broadly equated with male genital surgery by a number of commentators. If this is so, how can this form of female genital surgery be prohibited for all women yet male genital surgery remain legally sanctioned for all men? As Richards argued:

“[I]t is illogical that male circumcision has not been considered with [female genital mutilation] prohibition. Surgical cutting and disfiguring of a healthy genital organ is consistent with male and female circumcision ... the differences appear to be based largely on socially constructed ideals, and not on facts, it is suggested there should be no distinction based purely on gender.”

Hayter, in the context of female genital surgery in the United Kingdom, asked the following:

“[W]hat justification is required before minority groups should be legally compelled to discontinue practices which are fundamental to their culture?”

In Australia the answer to this question appears to lie in the dominant societal conception of what minority practices are “acceptable” and “unacceptable”. Male genital surgery was prevalent

75 Medicare Benefits Schedule 2000.
76 B Morris, In Favour of Circumcision (UNSW Press, Sydney, 1999).
77 Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 at 297.
78 Rogers v Whitaker (1992) 175 CLR 479 at 489.
79 Unreported, Sup Ct, NSW, 14 May 1987.
in Australia (and other Western liberal countries) for a great length of time as it is not viewed as "barbaric" and "savage" in the same way that female genital surgery is. It is perceived as far more easy to accommodate into Western liberal tradition. Female genital surgery has only a very minor role in the Western liberal tradition – clitoridectomies were at one stage performed on “hysterical” and “over-sexed women”. However, it was never routine and uniform in the way male genital surgery was. There is also a strong religious connection with male circumcision, and freedom of religion is a central constitutional tenet. This is significant in the conceptualisations of male and female genital surgery, as Povenmire argued: “[e]thnocentric distinctions between the ‘barbaric’ practice of FGM, and the ‘meaningful’ practice of Jewish circumcision, facilitated this distinction.”

There is also less desire to control the male body in the way the female body is monitored and regulated by the state. Thus, on one hand, female genital surgery is frequently seen as a method for the monitoring of “irresponsible” female sexuality. On the other hand, the debate, legislation and uproar over female genital surgery in Australia is also about controlling the female body. As one informant observed:

“I feel confused by the attitude here. I was not circumcised at home due to the war [between Eritrea and Ethiopia], and when I came here I started hearing about how it [female genital surgery] is a terrible and savage practice. That women have no control or power over their bodies or sexuality. Now that I am older, I would like to be circumcised before I marry, but I can’t because it is illegal. Does this mean I cannot chose either way? It is my body.”

Conclusions

This article does not condone female genital surgery; rather it interrogates the discourse that condemns it in Australia. As such, it seriously questions the way in which the current legislation prohibiting female genital surgery was constructed and its possible effectiveness in eliminating the practice. This is especially true in respect of adult women who are prohibited to consent to such surgery by the legislation. By contrast, an adult male can consent to male genital surgery for any reason he chooses. More importantly, parents can consent to genital surgery for their infant son, leaving serious questions unanswered. How can the rights of a child with relation to genital surgery remain gender-based? The only answer is that it persists for the same reason that the rights of an adult to consent to genital surgery remain gender-based: that is, certain minority practices are tolerated as acceptable within the rubric of dominant liberal values in Australia and others are not. The law simply reflects this dominant cultural blueprint to the detriment of alternative minority rights and opinions.

However, a more prolonged impact on infants is that among communities practising male and female genital surgery, the two are elided as acceptable and, in an unintended way, the current Australian legislation encourages this:

“Female circumcision will never stop as long as male circumcision is going on. How do you expect to convince an African father to leave his daughter uncircumcised as long as you let him do it to his son?”

Changes are required to educate against both male and female infant genital surgery whilst also amending the existing legislation in order to permit adult consent to such procedures. This both protects children and allows freedom of minority practices when a person is old enough to voluntarily and freely decide for himself or herself. In the long term, it may even lead to the eradication of the practice altogether.

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88 Lightfoot-Klein, op cit n 23, at 354.
89 Author’s interview, Sydney, January 2000.
90 Zwang, cited in Abu-Sahlieh, op cit n 18, at 612.