Recommendations on the management of patients with a history of female genital mutilation

Bundesärztekammer (German Medical Association)

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At its meeting of 25th November 2005, the Board of the German Medical Association adopted the following recommendation: Recommendations on the management of patients with a history of female genital mutilation

Introduction

The practice of female circumcision, especially the so-called ‘infibulation’, is outlawed and condemned throughout the world. The German medical profession has also emphatically reiterated this position. This tradition within some African cultures may not be assessed only in historical, political and ethical-moral terms, but the affected women must be given competent social, psychological and medical assistance that is appropriate to the level of suffering and complaints they experience. Especially in the gynaecological and obstetrical context, both the specific anatomy that results from FGM and the patient's wishes regarding delivery, surgery and wound management must be observed in functional, medical and psychological terms. The foregoing must be in line with the standards and duties of the medical profession. All aspects need to be considered to achieve satisfactory treatment outcomes. Ensuring these is the purpose of the following recommendations for medical practitioners that were drafted by a panel of expert lawyers and physicians and are issued by the German Medical Association.

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1) Background and Definition

Female genital mutilation is a very common practice, mainly in some parts of Africa. Mostly performed on infants, toddlers or young girls, it is a mutilating operation with many medical, psychological and social consequences.1

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1 Cf Swiss Recommendations for doctors, midwives and nurses: ‘Patientinnen mit genitaler Beschneidung’, http://www.sgfg.ch/, www.iamaneh.ch, that describe the medical, psychological and social implications in great detail. This document was drafted on the basis of these recommendations.
The WHO classification distinguishes four types of female genital mutilation

- Type I: 'Sunna': excision of the prepuce, with excision of part or all of the clitoris,
- Type II: 'Excision': removal of the clitoris with partial or total excision of the labia minora,
- Type III: 'Infibulation': removal of all or part of the external genitalia and sewing up of the orificium vaginae, leaving only a very small opening;
- Type IV: diverse practices that elude classification, such as pricking, piercing or incising or tearing the clitoris;

Most patients present with infibulation.

2) Legal and ethical aspects

Although FGM, which in most cases is not performed by medical practitioners, is socially accepted in the countries concerned, both this intervention and the involvement of medical practitioners in it must be condemned.

In Germany, this intervention is liable to punishment as bodily injury (section 223 of the StGB – Criminal Code), dangerous bodily injury (section 224 StGB), under certain circumstances serious bodily injury (section 226 StGB) as well as maltreatment of wards (section 225 StGB). This also applies if the intervention takes place at the patient's request (cf. Bundestags-Drucksache 13/8281 of 23rd July 1997).

In its general duty clause stipulated in section 2(2), the (Model) Professional Code for German Physicians states that: “Physicians must practise their profession conscientiously and do justice to the confidence placed in them in practising their profession.” Moreover, section 2(1) of the (Model) Professional Code, requires that: “Physicians practice their profession according to their conscience, the precepts of medical ethics and humaneness. They may not acknowledge any principles, or comply with any regulations or instructions, that are irreconcilable with their tasks or for whose observance they cannot answer.”

In line with the foregoing, the 99th Deutscher Ärztetag (German Medical Assembly) in Cologne adopted, in 1996, the following resolution on the ritual mutilation of female genitals: "The 99th German Medical Assembly condemns the participation of physicians in the performance of any type of female circumcision and warns that, according to the general duty clause of the professional code for German physicians, such practices are liable to punishment under professional law. In other European States (such as Norway, Denmark, France), the law already makes the ritual mutilation of female genitals subject to punishment."

This position was endorsed at the 100th German Medical Assembly in 1997: "According to the general duty clause of the professional code for German physicians, the performance of such practices is contrary to professional law. Genital mutilation denies girls and women fundamental human rights such as the right to life and development and the right to physical and psychological integrity."
3) Implications of female genital mutilation

Female genital mutilation is associated with the following acute and chronic complications:

a) Acute complications

- acute psychological trauma
- infection
- local infection
- abscess formation
- general infection
- septic shock
- HIV infection
- tetanus
- gangrene
- micturition problems
- urine retention
- edema of the urethra
- dysuria
- injury
- injury to adjacent organs
- fractures (femur, clavicula, humerus)
- bleeding
- hemorrhage
- shock
- anemia
- death

b) Chronic somatic complications

- sexuality/menstruation
- dyspareunia/apareunia
- vaginal stenosis
- infertility/sterility
- dysmenorrhoea
- menorrhagia
- chronic vaginitis, endometritis, adnexitis
- micturition problems
- recurrent urinary tract infections
- prolonged micturition
- incontinence
- vaginal crystals
- complications of scar tissue
- abscess formation
- keloid formation/dermoid cysts/neurilemmomas
- hematocolpos
- antenatal and perinatal complications
- vaginal examination difficult
- catheterisation impossible
- measurement of fetal scalp pH impossible
- expulsion period prolonged
• perineal tears
• postpartum hemorrhage
• perineal wound infection
• Vesico-vaginal / recto-vaginal fistulas
• perinatal mortality increased

c) Psychological and social implications

In most cases, genital mutilation causes serious indelible trauma that is both physical and psychological. The entire ordeal can become deeply engraved in the girl's subconscious mind and lead to behavioural disorders. Another grave consequence is the girl losing trust in her persons of reference. In the long term, therefore, these women tend to suffer from feelings of incompleteness, anxiety, depression, chronic irritability, frigidity and experience partnership problems. Many women traumatised by FGM have no way of expressing their feelings and fears and suffer in silence.

4) Care of affected women

Patients with a history of FGM, especially infibulation, require special medical and psychosocial care and counselling, mainly to mitigate its physical effects (genital infections, urinary infections, sterility issues) as well as the related sexual problems (sexual intercourse impossible, dyspareunia). The working group 'Frauengesundheit in der Entwicklungszusammenarbeit – FI DE' (Women's Health in International Development) has issued a statement on female genital mutilation on behalf of the Board of the Deutsche Gesellschaft für Geburtshilfe und Gynäkologie (German Society of Obstetrics and Gynaecology). Based on this statement, the following guidance is recommended for doctor-patient contacts:

• Sensitive history-taking, if necessary with a female interpreter (in one-to-one talks and/or talks with the family). When discussing these issues with the women, the term 'female circumcision' should be used.
• Sensitive case assessment and examination.
• Specific treatment of infections.
• Removal of obstructions to menstrual blood and urine flow.
• Depending on the extent of FGM, facilitating intercourse by opening the vaginal introitus under anesthesia (see item 5).
• Pregnant circumcised women with a narrow vaginal opening may have a medical need for surgical dilation already before coming to term, especially if vaginal and urinary infections have occurred during pregnancy. To avoid retraumatisation due to flashbacks of circumcision, appropriate anesthesia should be opted for.
• In the course of delivery, normal childbirth should be facilitated by defibulation, controlled perineal tears or episiotomy (see item 6).

5) Defibulation

A medical need for surgical 'reversal' of the infibulation may exist especially if the patient presents with related complaints (recurrent UTIs, menstrual problems), sterility due to the inability to have sexual intercourse, and sexual disorders (particularly dyspareunia). Medical indications are, specifically:

• patient's wishes
• difficulties passing urine
• difficulty having sexual intercourse
• keloid formation in scar tissue
• severe dysmenorrhoea
Any intervention requires specific prior counselling that addresses the medical aspects and is culturally sensitive. The intervention must be done under anesthesia to avoid flashbacks of a possible trauma.

6) Defibulation before or during delivery and subsequent wound management

In antenatal care, the obstetrician has to assess the extent to which genital mutilation can obstruct delivery. At this point in time, the possible need for defibulation during childbirth should already be discussed, whereby the medical, psychological and social aspects both of opening up and postnatal wound management must be addressed. This discussion should aim to secure consent to restore the patient's vaginal introitus in the course of postnatal wound management in an effort to prevent the problems listed under item 5.

To spare the patient the experience of two surgical interventions, defibulation should, if possible, only take place during childbirth.

Postnatal wound management is based on what has been agreed with the patient during pregnancy in respect of the opening of the infibulation and wound management after delivery. Forms of genital closing that are likely to lead to medical problems such as recurrent bladder infections, retention of menstrual discharge or difficulty having sexual intercourse may not be performed.

7) Legal and ethical discussion of wound management

In legal terms, a distinction is to be made between the various forms of (primary) genital mutilation and wound management. While the first amounts to serious bodily injury, the second is a medically necessary intervention. Postnatal wound management aims to treat the raw scars and the perineal tear or episiotomy.

Like any other therapeutic treatment, these may only be done with the patient's informed consent. Education and information are essential in treating the women affected. In addition to explaining to the woman what the medical treatment involves in easily understandable language, the information has to appropriately consider her special situation.

If, after having been informed, infibulated women demand to be restored to their physical state before delivery, the doctor must refuse treatment if it would obviously endanger the woman's health, since he or she would be committing an act of dangerous bodily injury no different from the original infibulation.

The doctor is obliged to treat the woman's existing wounds in such a way as to prevent any health impairment. The desired treatment outcome is the restoration of the woman's physical and psychological well-being.

8) Psychosocial counselling of women with female genital mutilation

Women who have had female genital mutilation represent a relatively small part of the residential population in Germany. Staff in the psychosocial counselling centres in place have little training and experience with the peculiar problems of women with FGM. Especially in the cities, there-
fore, staff of existing counselling centres (such as for migrant women) should be trained to deal with this issue or new counselling centres should be set up that also address this special problem. This requires a framework that includes both the governmental counselling centres and the voluntary, non-profit counselling centres.

9) Prevention for newborn daughters

In keeping with their cultural background, some expectant mothers wish to arrange for their newborn daughters to be circumcised, as well. This must be avoided at all costs.

Counselling of the mothers should address the medical, psychological and social effects of FGM. Since other options of initiation into the cultural community exist, these women can be relieved of the pressure to conform to their cultural background. Delivery in a hospital may offer the only opportunity for timely or preventative counselling on this issue. In the interest of newborn girls, therefore, good use should be always be made of this opportunity.

8) Release from confidentiality

The Federal Child Protection Act (BKISHG) entitles physicians to refer a child to the youth office when they have reasonable grounds to assume that the child’s welfare is at risk, even without consent to disclosure of health information, if discussing the situation with the persons who have the care and custody of the child is impossible or fruitless; this option must be brought to the attention of the persons affected beforehand, unless doing so would compromise the effective protection of the child or young person.

Irrespective of the foregoing, third persons may be called in even if consent to medical disclosure has not been given if doing so is justified by necessity in line with section 34 of the Criminal Code (StGB)².

9) Outlook

The only way of eradicating the practice of female genital mutilation is through political and social measures in the countries of origin.

The task of medical practitioners and psychosocial counselling centres in Germany is to provide the women with care that respects their cultural background, responds in a sensitive way and seeks to find individual conflict-solving strategies.

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² Section 34 Criminal Code (StGB) Necessity as justification
Whoever, faced with an imminent danger to life, limb, freedom, honour, property or another legal interest which cannot otherwise be averted, commits an act to avert the danger from himself or another, does not act unlawfully, if, upon weighing the conflicting interests, in particular the affected legal interests and the degree of danger threatening them, the protected interest substantially outweighs the one interfered with. This shall apply, however, only to the extent that the act is a proportionate means to avert the danger.
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