MORAL RELATIVISM

A Reader

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Female Circumcision/ Genital Mutilation and Ethical Relativism

LORETTA M. KOPELMAN

In Northern Africa and Southern Arabia many girls undergo ritual surgery involving removal of parts of their external genitalia; the surgery is often accompanied by ceremonies intended to honor and welcome the girls into their communities. About 80 million living women have had this surgery, and an additional 4 or 5 million girls undergo it each year (Kouba and Muasher 1985; Ntiri 1993). Usually performed between infancy and puberty, these ancient practices are supposed to promote chastity, religion, group identity, cleanliness, health, family values, and marriage goals. This tradition is prevalent and deeply embedded in many countries, including Ethiopia, the Sudan, Somalia, Sierra Leone, Kenya, Tanzania, Central African Republic, Chad, Gambia, Liberia, Mali, Senegal, Eritrea, Ivory Coast, Upper Volta, Mauritania, Nigeria, Mozambique, Botswana, Lesotho, and Egypt (Abdalla 1982; Ntiri 1993; Calder et al. 1993; Rushwan 1990; El Dareer 1982; Koso-Thomas 1987). Modified versions of the surgeries are also performed in Southern Yemen and Musqat-Oman (Abdalla 1982). Tragically, the usual ways of performing these surgeries deny women sexual orgasms, cause significant morbidity or mortality among women and children, and strain the overburdened health care systems in these developing countries. Some refer to these practices as *female circumcision,* but those wishing to stop them increasingly use the description *female genital mutilation.*

Impassioned cultural clashes erupt when people from societies practicing female circumcision/genital mutilation settle in other parts of the world and bring these rites with them. It is practiced, for example, by Muslim groups in the Philippines, Malaysia, Pakistan, Indonesia, Europe, and North America (Kluge 1993; Thompson 1989; Abdalla 1982; Koso-Thomas 1987). Parents may use traditional practitioners or seek medical facilities to reduce the morbidity or mortality of this genital surgery. Some doctors and nurses

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perform the procedures for large fees or because they are concerned about the unhygienic techniques that traditional practitioners may use. In the United Kingdom, where about 2,000 girls undergo the surgery annually, it is classified as child abuse (Thompson 1989). Other countries have also classified it as child abuse, including Canada and France (Kluge 1993).

Many international agencies like UNICEF, the International Federation of Gynecology and Obstetrics, and the World Health Organization (WHO) openly condemn and try to stop the practices of female genital mutilation (WHO 1992; Rushwan 1990). Such national groups as the American Medical Association (AMA 1991) have also denounced these rituals. Women's groups from around the world protest these practices and the lack of notice they receive. (A common reaction to the attention given to the Bobbitt case, where an abused wife cut off her husband's penis, was, "Why was there a media circus over one man's penis while the excision of the genitalia of millions of girls annually receives almost no attention?")

Most women in cultures practicing female circumcision/genital mutilation, when interviewed by investigators from their culture, state that they do not believe that such practices deprive them of anything important (Koso-Thomas 1987). They do not think that women can have orgasms or that sex can be directly pleasing to women but assume that their pleasure comes only from knowing they contribute to their husbands' enjoyment (El Dareer 1982; Abdalla 1982). Some critics argue that women who hold such beliefs cannot be understood to be making an informed choice; they thus condemn this custom as a form of oppression (Sherwin 1992; Walker 1992).

International discussion, criticisms, and condemnation of female circumcision/genital mutilation help activists who struggle to change these rites that are thoroughly entrenched in their own cultures (El Dareer 1982; Ntiri 1993; Kouba and Muasher 1985; Koso-Thomas 1987; Abdalla 1982). Not surprisingly, people who want to continue these practices resent such criticisms, seeing them as assaults upon their deeply embedded and popular cultural traditions.

Underlying intercultural disputes is often a basic moral controversy: Does praise or criticism from outside a culture or society have any moral authority within it? That is, do the moral judgments from one culture have any relevance to judgments about what is right or wrong within another culture? According to some versions of ethical relativism, to say that something is right means that it is approved of in the speaker's culture; to say that something is wrong means that it is disapproved. If this is correct, there is no rational basis for establishing across cultures that one set of culturally established moral values is right and the other wrong. The right action is one that is approved by the person's society or culture, and the wrong action is one that is disapproved by the person's society or culture; there are moral truths, but they are determined by the norms of the society. On this view, then, the cultural approval of female circumcision/genital mutilation means that the practice is right; disapproval means that it is wrong.

In contrast to such versions of ethical relativism, other traditions hold

that to say something is morally right means that the claim can be defended with reasons in a certain way. Saying that something is approved (such as slavery) does not settle whether it is right, because something can be wrong even when it is approved by most people in a culture. Moral judgments do not describe what is approved but prescribe what ought to be approved; if worthy of being called moral or ethical judgments, they must be defensible with reasons that are consistent and empirically defensible. As we shall find, advocates of the practice of female circumcision/genital mutilation do not say, "We approve of these rituals, and that is the end of the matter." Rather, they try to defend the practice as useful in promoting many important goals. In fact, however, the practice is inconsistent with important goals and values of the cultures in which it is practiced. We find that we can evaluate some of the reasons given for performing these rituals and that despite our cultural differences about what to value and how to act, we share many methods of discovery, evaluation, and explanation. These enable us sometimes correctly to judge other cultures, and they us. Moral judgments can be evaluated at least in terms of their consistency and their relation to stable evidence, like medical or scientific findings. By this means certain moral claims can be challenged, even where we have different cultural values, and the practice of female circumcision/genital mutilation shown to be wrong. Thus, both intercultural and intracultural discussions, criticisms, and condemnation of female genital mutilation as well as support for activists seeking to stop the practice can have moral authority, or so I argue.

After considering some of the health hazards of female circumcision/genital mutilation, I review the version of ethical relativism that denies moral authority to cross-cultural moral judgments. By examining the cultural reasons used to justify female circumcision/genital mutilation. I want to show that many aspects of this discussion are open to cross-cultural evaluation and understanding and hence that this version of ethical relativism fails. After discussing some anticipated objections, I conclude that these relativists have a heavy burden of proof to show why we cannot make intercultural judgments that have moral force concerning female genital mutilation, just as we do concerning such things as oppression, intolerance, exploitation, waste, aggression, and torture or imprisonment of dissidents.

TYPES OF SURGERY AND THEIR HEALTH CONSEQUENCES

Female circumcision/genital mutilation takes three forms. Type 1 circumcision involves pricking or removing the clitoral hood, or prepuce. This is the least mutilating type and should not preclude sexual orgasms in later life, unlike other forms. When this surgery is performed on infants and small children, however, it may be difficult to avoid removal of additional tissue, because infants genitalia are small, and the tools commonly used are pins, scissors, razors, and knives. In the southern Arabian countries of Southern

Yemen and Musqat-Oman, Type 1 circumcision is commonly practiced.[1] In African countries, however, Type 1 circumcision is often not regarded as a genuine circumcision (Koso-Thomas 1987; Abdalla 1982). Only about 3 percent of the women in one east African survey had this type of circumcision (El Dareer 1982), and none in another (Ntiri 1993) where all the women surveyed had been circumcised.

Type 2, or intermediary, circumcision involves removal of the clitoris and most or all of the labia minora. In Type 3 circumcision, or infibulation, the clitoris, labia minora, and parts of the labia majora are removed. The gaping wound to the vulva is stitched tightly closed, leaving a tiny opening so that the woman can pass urine and menstrual flow. (Type 3 is also known as Pharaonic circumcision, suggesting that it has been done since the time of the pharaohs [Abdalla 1982].) In some African countries most young girls between infancy and 10 years of age have Type 3 circumcision (Abdalla 1982; Ntiri 1993; Calder et al. 1993). Traditional practitioners often use sharpened or hot stones, razors, or knives, frequently without anesthesia or antibiotics (Rushwan 1990; Abdalla 1982; El Dareer 1982). In many communities thorns are used to stitch the wound closed, and a twig is inserted to keep an opening. The girl's legs may be bound for a month or more while the scar heals (Abdalla 1982; El Dareer 1982).[2]

Types 2 and 3, both of which preclude orgasms, are the most popular forms. More than three-quarters of the girls in the Sudan, Somalia, Ethiopia, and other north African and southern Arabian countries undergo Type 2 or Type 3 circumcision, with many of the others circumcised by Type 1 (El Dareer 1982; Ntiri 1993; Calder et al. 1993; Koso-Thomas 1987; Ogiamien 1988). One survey by Sudanese physician Asma El Dareer (1982) shows that over 98 percent of Sudanese women have had this ritual surgery, 12 percent with Type 2 and 83 percent with Type 3. A 1993 study of 859 Somali women finds that all were circumcised, 98 percent with Type 3 and 2 percent with Type 2; on 70 percent of them, the surgery was done with a machete (Ntiri 1993).

Medical science is divided over whether the practice of male circumcision has any benefits (see American Academy of Pediatrics 1989 and Alibhai 1993 for discussion of the pros and cons). In contrast, female circumcision/genital mutilation has no benefits and is harmful in many ways, with both short- and long-term complications documented in a series of studies from Nigeria (Ozumba 1992), the Sudan (El Dareer 1982), Sierra Leone (Koso-Thomas 1987), and Somalia (Abdalla 1982; Ntiri 1993; Dirie and Lindmark 1992).

Almost all girls experience immediate pain following the surgery (Rushwan 1990; El Dareer 1982). El Dareer found other immediate consequences, including bleeding, infection, and shock correlating with the type of circumcision: Type 1, 8.1 percent; Type 2, 24.1 percent; and Type 3, 25.6 percent. Bleeding occurred in all forms of circumcision, accounting for 21.3 percent of the immediate medical problems in El Dareer's survey. She writes, "Hemorrhage can be either primary, from injuries to arteries or veins, or secondary, as a result of infection" (1982:33). Infections are frequent because the surgical conditions are often unhygienic (Rushwan 1990; El Dareer 1982). The inability to pass urine was common, constituting 21.65 percent of the immediate complications (El Dareer 1982). El Dareer found 32.2 percent of the women surveyed had long-term problems, with 24.54 percent suffering urinary tract infections and 23.8 percent suffering chronic pelvic infection. The published studies by investigators from the regions where these rituals are practiced uniformly find that women expressed similar complaints and had similar complications from female circumcision/genital mutilation: at the site of the surgery, scarring can make penetration difficult and intercourse painful; cysts may form, requiring surgical repairs; a variety of menstrual problems arise if the opening left is too small to allow adequate drainage; fistulas or tears in the bowel or urinary tract are common, causing incontinence, which in turn leads to social as well as medical problems; maternal-fetal complications and prolonged and obstructed labor are also well-established consequences (Kouba and Muasher 1985; Rushwan 1990; El Dareer 1982; Koso-Thomas 1987; Abdalla 1982; Ozumba 1992; Ntiri 1993; Dirie and Lindmark 1992; Ogiamien 1988; Thompson 1989). El Dareer (1982:iii–iv) writes, "The result almost invariably causes immediate and long-term medical complications, especially at childbirth. Consummation of marriage is always a difficult experience for both partners, and marital problems often result. Psychological disturbances in girls due to circumcision are not uncommon." The operation can also be fatal because of shock, tetanus, and septicemia (Rushwan 1990).

As high as the rates of these reported complications are, investigator El Dareer (1982) believes that the actual rates are probably even higher for several reasons. First, female circumcision/genital mutilation, although widely practiced, is technically illegal, and people are reluctant to discuss illegal activities.[3] Second, people may be ashamed to admit that they have had complications, fearing they are to blame for them. Third, some women believe that female circumcision/genital mutilation is necessary for their health and well-being and so may not fully associate these problems with the surgery but assume that their problems would have been worse if they had been uncircumcised. Many women, as these studies show, are well aware of the complications from this ritual surgery. Nonetheless they strongly support continuing these practices. One study (Ntiri 1993) reports that 92 percent of the Somali women surveyed favor continuing Type 3 (76 percent) or Type 2 (24 percent) for their daughters.

ETHICAL RELATIVISM

Female circumcision/genital mutilation serves as a test case for some versions of ethical relativism because the practice has widespread approval within the cultures where it is practiced and widespread disapproval outside those cultures. *Relativism*, however, means different things to different "aca-

demic cultures." Indeed one of the most striking things about the term *relativism* is that it is used in so many different ways, spanning the banal to the highly controversial. In the *Encyclopedia of Philosophy,* Richard D. Brandt (1967:75) writes, "Contemporary philosophers generally apply the term [ethical relativism] to some position they disagree with or consider absurd, seldom to their own views; social scientists, however, often classify themselves as relativists." Philosophers and those in religious studies often distinguish two ways to understand relativism: one is controversial, and the other is not (Brandt 1967; Sober 1991). The noncontroversial, descriptive version, often called *descriptive relativism,* is the view that people from different cultures *do* act differently and have distinct norms. Social scientists often work as descriptive relativists: they try to understand cultural differences and look for any underlying similarities. Those studying or criticizing female circumcision/genital mutilation, of course, recognize that we do act differently and have different values. But descriptions about how or in what way we *are* different do not entail statements about how we *ought* to act.

The controversial position, called *ethical relativism,* is that an action is right if it is approved in a person's culture and wrong if it is disapproved. Another version of this controversial view is that to say something is right means it has cultural approval; to say something is wrong means it has cultural disapproval. According to this view, which some call *cultural relativism* (Holmes 1993), there is no way to evaluate moral claims across cultures; positions taken by international groups like the World Health Organization merely express a cluster of particular societal opinions and have no moral standing in other cultures. On this view it is incoherent to claim that something is wrong in a culture yet approved, or right yet disapproved; people can express moral judgments about things done in their own or other cultures, but they are expressing only their cultural point of view, not one that has moral authority in another culture.

Many social scientists and (despite what Brandt says) some philosophers defend ethical relativism. For example, philosopher Bernard Williams (1985) argues that moral knowledge is inherited by people within particular cultural traditions and has objectivity only within those cultures. Anthropologists Faye Ginsberg (1991) and Nancy Scheper-Hughes (1991) point out that ethical relativism has held an important place in anthropology despite the uncomfortable consequence that acceptance of that position means that practices like female circumcision are right within the cultures where they are approved. Anthropologists by their own admission, however, do not use the terms *cultural relativism* or *ethical relativism* consistently (Shweder 1990). Often relativism is presented as the only alternative to clearly implausible views such as absolutism or cultural imperialism; sometimes it is used to stress the obvious points that different rankings and interpretations of moral values or rules by different groups may be justifiable, or employed to highlight the indisputable influence of culture on moral development, reasoning, norms, and decisions. It may also be used to show that decisions about what we ought to do depend on the situation—for example, that it may not be

wrong to lie in some cases. These points are not in dispute herein or even controversial, so my comments do not apply to these versions of relativism.

Nor do the criticisms offered herein necessarily challenge relativists who agree that cross-cultural moral judgments sometimes have moral force. Generally they wish to accent the role of culture in shaping our moral judgments, showing why it is dangerous to impose external cultural judgments hastily or stressing that there is often a link between established moral systems and oppression. For example, moral philosopher Susan Sherwin maintains that "normative conclusions reached by traditional theorists generally support the mechanism of oppression; for example, by promoting subservience among women" and concludes, "Feminist moral relativism remains absolutist on the question of the moral wrong of oppression but is relativist on other moral matters" (1992:58, 75). She uses this form of relativism to argue that female circumcision is wrong.

In contrast, the distinctive feature of the version of ethical relativism criticized herein is its defense of the skeptical position that one can *never* make a sound cross-cultural moral judgment, that is, one that has moral force outside one's culture.[4] This version of ethical relativism is false if people from one culture can *sometimes* make judgments that have moral authority about actions in another society. Its defenders regard their view to be the consequence of a proper understanding of the limits of knowledge (Williams 1985; Ginsberg 1991; Shweder 1990). Many attacks, however, have been made on the skepticism underlying such ethical relativism (Bambrough 1979; Hampshire 1989), and my remarks are in this tradition.

I would begin by observing that we seem to share methods of discovery, evaluation, negotiation, and explanation that can be used to help assess moral judgments. For example, we agree how to evaluate methods and research in science, engineering, and medicine, and on how to translate, debate, deliberate, criticize, negotiate, and use technology. To do these things, however, we must first have agreed to some extent on how to distinguish good and bad methods and research in science, engineering, and medicine, and what constitutes a good or bad translation, debate, deliberation, criticism, negotiation, or use of technology. These shared methods can be used to help evaluate moral judgments from one culture to another in a way that sometimes has moral authority. An example of a belief that could be evaluated by stable medical evidence is the assertion by people in some regions that the infant's "death could result if, during delivery, the baby's head touches the clitoris" (Koso-Thomas 1987:10). In addition, some moral claims can be evaluated in terms of their coherence. It seems incompatible to promote maternal-fetal health as a good and also to advocate avoidable practices known to cause serious perinatal and neonatal infections.

We need not rank values similarly with people in another culture, or our own, to have coherent discussions about their consistency, consequences, or factual presuppositions. That is, even if some moral or ethical (I use these terms interchangeably) judgments express unique cultural norms, they may still be morally evaluated by another culture on the basis of their logical con-

sistency and their coherence with stable and cross-culturally accepted empirical information. In addition, we seem to share some moral values, goals, and judgments such as those about the evils of unnecessary suffering and lost opportunities, the need for food and shelter, the duty to help children, and the goods of promoting public health and personal well-being (Hampshire 1989). Let us consider, therefore, the reasons given by men and women who practice female circumcision/genital mutilation in their communities. The information presented herein is based upon studies done by investigators who come from these cultures, some of whom had this ritual surgery as children (El Dareer is one such investigator). We can examine whether these reasons allow people from other cultures any way of entering the debate based upon such considerations as consistency or stable medical findings.

REASONS GIVEN FOR FEMALE CIRCUMCISION/GENITAL MUTILATION

According to four independent series of studies conducted by investigators from countries where female circumcision is widely practiced (El Dareer 1982; Ntiri 1993; Koso-Thomas 1987; Abdalla 1982), the primary reasons given for performing this ritual surgery are that it (1) meets a religious requirement, (2) preserves group identity, (3) helps to maintain cleanliness and health, (4) preserves virginity and family honor and prevents immorality, and (5) furthers marriage goals including greater sexual pleasure for men.

El Dareer conducted her studies in the Sudan, Dr. Olayinka Koso-Thomas in and around Sierra Leone, and Raquiya Haji Dualeh Abdalla and Daphne Williams Ntiri in Somalia. They argue that the reasons for continuing this practice in their respective countries float on a sea of false beliefs, beliefs that thrive because of a lack of education and open discussion about reproduction and sexuality. Insofar as intercultural methods for evaluating factual and logical statements exist, people from other cultures should at least be able to understand these inconsistencies or mistaken factual beliefs and use them as a basis for making some judgments having intercultural *moral* authority.

First, according to these studies the main reason given for performing female circumcision/genital mutilation is that it is regarded as a religious requirement. Most of the people practicing this ritual are Muslims, but it is not a practice required by the Koran (El Dareer 1982; Ntiri 1993). El Dareer writes:

> Circumcision of women is not explicitly enjoined in the Koran, but there are two implicit sayings of the Prophet Mohammed: "Circumcision is an ordinance in men and an embellishment in women" and, reportedly Mohammed said to Om Attiya, a woman who circumcised girls in El Medina, "Do not go deep. It is more illuminating to the face and more enjoyable to the husband." Another version says, "Reduce but do not destroy. This is enjoyable to the woman and preferable to the man." But there is nothing in the Koran to suggest that the Prophet commanded that women be circumcised. He advised that it was important to both sexes that very little should be taken. (1992:72)

Female circumcision/genital mutilation, moreover, is not practiced in the spiritual center of Islam, Saudi Arabia (Calder et al. 1993). Another reason for questioning this as a Muslim practice is that clitoridectomy and infibulation predate Islam, going back to the time of the pharaohs (Abdalla 1982; El Dareer 1992).

Second, many argue that the practice helps to preserve group identity. When Christian colonialists in Kenya introduced laws opposing the practice of female circumcision in the 1930s, African leader Kenyatta expressed a view still popular today:

> This operation is still regarded as the very essence of an institution which has enormous educational, social, moral and religious implications, quite apart from the operation itself. For the present, it is impossible for a member of the [Kikuyu] tribe to imagine an initiation without clitoridectomy . . . the abolition of IRUA [the ritual operation] will destroy the tribal symbol which identifies the age group and prevent the Kikuyu from perpetuating that spirit of collectivism and national solidarity which they have been able to maintain from time immemorial. (Scheper-Hughes 1991:27)

In addition, the practice is of social and economic importance to older women who are paid for performing the rituals (El Dareer 1982; Koso-Thomas 1987; Abdalla 1982; Ginsberg 1991).

Drs. Koso-Thomas, El Dareer, and Abdalla agree that people in these countries support female circumcision as a good practice, but only because they do not understand that it is a leading cause of sickness or even death for girls, mothers, and infants, and a major cause of infertility, infection, and maternal-fetal and marital complications. They conclude that these facts are not confronted because these societies do not speak openly of such matters. Abdalla writes, "There is no longer any reason, given the present state of progress in science, to tolerate confusion and ignorance about reproduction and women's sexuality" (1982:2). Female circumcision/genital mutilation is intended to honor women as male circumcision honors men, and members of cultures where the surgery is practiced are shocked by the analogy of clitoridectomy to removal of the penis (El Dareer 1982).

Third, the belief that the practice advances health and hygiene is incompatible with stable data from surveys done in these cultures, where female circumcision/genital mutilation has been linked to mortality or morbidity such as shock, infertility, infections, incontinence, maternal-fetal complications, and protracted labor. The tiny hole generally left for blood and urine to pass is a constant source of infection (El Dareer 1982; Koso-Thomas 1987; Abdalla 1982; Calder et al. 1993; Ntiri 1993). Koso-Thomas writes,

> As for cleanliness, the presence of these scars prevents urine and menstrual flow escaping by the normal channels. This may lead to acute retention of

> urine and menstrual flow, and to a condition known as *hematocolpos*, which is highly detrimental to the health of the girl or woman concerned and causes odors more offensive than any that can occur through the natural secretions. (Koso-Thomas 1987:10).

Investigators completing a recent study wrote:

> The risk of medical complications after female circumcision is very high as revealed by the present study [of 290 Somali women, conducted in the capital of Mogadishu]. Complications which cause the death of the young girls must be a common occurrence especially in the rural areas. . . . Dribbling urine incontinence, painful menstruations, haematocolpos and painful intercourse are facts that Somali women have to live with—facts that strongly motivate attempts to change the practice of female circumcision. (Dirie and Lindmark 1992:482)

Fourth, investigators found that circumcision is thought necessary in these cultures to preserve virginity and family honor and to prevent immorality. Type 3 circumcision is used to keep women from having sexual intercourse before marriage and conceiving illegitimate children. In addition, many believe that Types 2 and 3 circumcision must be done because uncircumcised women have excessive and uncontrollable sexual drives. El Dareer, however, believes that this view is not consistently held—that women in the Sudan are respected and that Sudanese men would be shocked to apply this sometimes-held cultural view to members of their own families. This reason also seems incompatible with the general view, which investigators found was held by both men and women in these cultures, that sex cannot be pleasant for women (El Dareer 1982; Koso-Thomas 1987; Abdalla 1982). In addition, female circumcision/genital mutilation offers no foolproof way to promote chastity and can even lead to promiscuity because it does not diminish desire or libido even where it makes orgasms impossible (El Dareer 1982). Some women continually seek experiences with new sexual partners because they are left unsatisfied in their sexual encounters (Koso-Thomas 1987). Moreover, some pretend to be virgins by getting stitched up tightly again (El Dareer 1982).

Fifth, interviewers found that people practicing female circumcision/genital mutilation believe that it furthers marriage goals, including greater sexual pleasure for men. To survive economically, women in these cultures must marry, and they will not be acceptable marriage partners unless they have undergone this ritual surgery (Abdalla 1982; Ntiri 1993). It is a curse, for example, to say that someone is the child of an uncircumcised woman (Koso-Thomas 1987). The widely held belief that infibulation enhances women's beauty and men's sexual pleasure makes it difficult for women who wish to marry to resist this practice (Koso-Thomas 1987; El Dareer 1992). Some men from these cultures, however, report that they enjoy sex more with uncircumcised women (Koso-Thomas 1987). Furthermore, female circumcision/genital mutilation is inconsistent with the established goals of some of these cultures because it is a leading cause of disability and contributes to the high

mortality rate among mothers, fetuses, and children. Far from promoting the goals of marriage, it causes difficulty in consummating marriage, infertility, prolonged and obstructed labor, and morbidity and mortality.

CRITICISMS OF ETHICAL RELATIVISM

Examination of the debate concerning female circumcision suggests several conclusions about the extent to which people from outside a culture can understand or contribute to moral debates within it in a way that has moral force. First, the fact that a culture's moral and religious views are often intertwined with beliefs that are open to rational and empirical evaluation can be a basis of cross-cultural examination and intercultural moral criticism (Bambrough 1979). Defenders of female circumcision/genital mutilation do not claim that this practice is a moral or religious requirement and end the discussion; they are willing to give and defend reasons for their views. For example, advocates of female circumcision/genital mutilation claim that it benefits women's health and well-being. Such claims are open to cross-cultural examination because information is available to determine whether the practice promotes health or causes morbidity or mortality. Beliefs that the practice enhances fertility and promotes health, that women cannot have orgasms, and that allowing the baby's head to touch the clitoris during delivery causes death to the baby are incompatible with stable medical data (Koso-Thomas 1987). Thus an opening is allowed for genuine cross-cultural discussion or criticism of the practice.

Some claims about female circumcision/genital mutilation, however, are not as easily open to cross-cultural understanding. For example, cultures practicing the Type 3 surgery, infibulation, believe that it makes women more beautiful. For those who are not from these cultures, this belief is difficult to understand, especially when surveys show that many women in these cultures, when interviewed, attribute to infibulation their keloid scars, urine retention, pelvic infections, puerperal sepsis, and obstetrical problems (Ntiri 1993; Abdalla 1982). Koso-Thomas writes:

> None of the reasons put forward in favor of circumcision have any real scientific or logical basis. It is surprising that aesthetics and the maintenance of cleanliness are advanced as grounds for female circumcision. The scars could hardly be thought of as contributing to beauty. The hardened scar and stump usually seen where the clitoris should be, or in the case of the infibulated vulva, taut skin with an ugly long scar down the middle, present a horrifying picture. (Koso-Thomas 1987:10)

Thus not everyone in these cultures believes that these rituals enhance beauty; some find such claims difficult to understand.

Second, the debate over female circumcision/genital mutilation illustrates another difficulty for defenders of this version of ethical relativism con-

cerning the problem of differentiating cultures. People who brought the practice of female circumcision/genital mutilation with them when they moved to another nation still claim to be a distinct cultural group. Some who moved to Britain, for example, resent the interference in their culture represented by laws that condemn the practice as child abuse (Thompson 1989). If ethical relativists are to appeal to cultural approval in making the final determination of what is good or bad, right or wrong, they must tell us how to distinguish one culture from another.

How exactly do we count or separate cultures? A society is not a nation-state, because some social groups have distinctive identities within nations. If we do not define societies as nations, however, how do we distinguish among cultural groups, for example, well enough to say that an action is child abuse in one culture but not in another? Subcultures in nations typically overlap and have many variations. Even if we could count cultural groups well enough to say exactly how to distinguish one culture from another, how and when would this be relevant? How big or old or vital must a culture, subculture, group, or cult be in order to be recognized as a society whose moral distinctions are self-contained and self-justifying?

A related problem is that there can be passionate disagreement, ambivalence, or rapid changes within a culture or groups over what is approved or disapproved. According to ethical relativism, where there is significant disagreement within a culture there is no way to determine what is right or wrong. But what disagreement is significant? As we saw, some people in these cultures, often those with higher education, strongly disapprove of female circumcision/genital mutilation and work to stop it (El Dareer 1982; Koso-Thomas 1987; Ntiri 1993; Dirie and Lindmark 1992; Abdalla 1982). Are they in the same culture as their friends and relatives who approve of these rituals? It seems more accurate to say that people may belong to various groups that overlap and have many variations. This description, however, makes it difficult for ethical relativism to be regarded as a helpful theory for determining what is right or wrong. To say that something is right when it has cultural approval is useless if we cannot identify the relevant culture. Moreover, even where people agree about the rightness of certain practices, such as these rituals, they can sometimes be inconsistent. For example, in reviewing reasons given within cultures where female circumcision/genital mutilation is practiced, we saw that there was some inconsistency concerning whether women needed this surgery to control their sexual appetites, to make them more beautiful, or to prevent morbidity or mortality. Ethical relativists thus have extraordinary problems offering a useful account of what counts as a culture and establishes cultural approval or disapproval.

Third, despite some clear disagreement such as that over the rightness of female circumcision/genital mutilation, people from different parts of the world share common goals like the desirability of promoting people's health, happiness, opportunities, and cooperation, and the wisdom of stopping war, pollution, oppression, torture, and exploitation. These common goals make us a world community, and using shared methods of reasoning and evaluation, we can discuss how they are understood or how well they are implemented in different parts of our world community. We can use these shared goals to assess whether female circumcision/genital mutilation is more like respect or oppression, more like enhancement or diminishment of opportunities, or more like pleasure or torture. While there are, of course, genuine differences between citizens of the world, it is difficult to comprehend how they could be identified unless we could pick them out against a background of our similarities. Highlighting our differences, however useful for some purposes, should not eclipse the truth that we share many goals and values and are similar enough that we can assess each other's views as rational beings in a way that has moral force. Another way to express this is to say that we should recognize universal human rights or be respectful of each other as persons capable of reasoned discourse.

Fourth, this version of ethical relativism, if consistently held, leads to the abhorrent conclusion that we cannot make intercultural judgments with moral force about societies that start wars, practice torture, or exploit and oppress other groups; as long as these activities are approved in the society that does them, they are allegedly right. Yet the world community believed that it was making a cross-cultural judgment with moral force when it criticized the Communist Chinese government for crushing a pro-democracy student protest rally, the South Africans for upholding apartheid, the Soviets for using psychiatry to suppress dissent, and the Bosnian Serbs for carrying out the siege of Sarajevo. And the judgment was expressed without anyone's ascertaining whether the respective actions had widespread approval in those countries. In each case, representatives from the criticized society usually said something like, "You don't understand why this is morally justified in our culture even if it would not be in your society." If ethical relativism were convincing, these responses ought to be as well.

Relativists who want to defend sound social cross-cultural and moral judgments about the value of freedom and human rights in other cultures seem to have two choices. On the one hand, if they agree that some cross-cultural norms have moral authority, they should also agree that some intercultural judgments about female circumcision/genital mutilation may have moral authority. Some relativists take this route (see, for example, Sherwin 1992), thereby abandoning the version of ethical relativism being criticized herein. On the other hand, if they defend this version of ethical relativism yet make cross-cultural moral judgments about the importance of values like tolerance, group benefit, and the survival of cultures, they will have to admit to an inconsistency in their arguments. For example, anthropologist Scheper-Hughes (1991) advocates tolerance of other cultural value systems; she fails to see that she is saying that tolerance between cultures is *right* and that this is a cross-cultural moral judgment using a moral norm (tolerance). Similarly, relativists who say it is wrong to eliminate rituals that give meaning to other cultures are also inconsistent in making a judgment that presumes to have genuine cross-cultural moral authority. Even the sayings sometimes used by defenders of ethical relativism—such as "When in Rome do as the Romans"

(Scheper-Hughes 1991)—mean it is *morally permissible* to adopt all the cultural norms in operation wherever one finds oneself. Thus it is not consistent for defenders of this version of ethical relativism to make intercultural moral judgments about tolerance, group benefit, intersocietal respect, or cultural diversity.

The burden of proof, then, is upon defenders of this version of ethical relativism to show why we cannot do something we think we sometimes do very well, namely, engage in intercultural moral discussion, cooperation, or criticism and give support to people whose welfare or rights are in jeopardy in other cultures. In addition, defenders of ethical relativism need to explain how we can justify the actions of international professional societies that take moral stands in adopting policy. For example, international groups may take moral stands that advocate fighting pandemics, stopping wars, halting oppression, promoting health education, or eliminating poverty, and they seem to have moral authority in some cases. Some might respond that our professional groups are themselves cultures of a sort. But this response raises the already discussed problem of how to individuate a culture or society.

OBJECTIONS

Some standard rejoinders are made to criticism of relativism, but they leave untouched the arguments against the particular version of ethical relativism discussed herein. First, some defenders argue that cross-cultural moral judgments perpetuate the evils of absolutism, cultural dogmatism, or cultural imperialism. People rarely admit to such transgressions, often enlisting medicine, religion, science, or the "pure light of reason" to arrive at an allegedly impartial, disinterested, and justified conclusion that they should "enlighten" and "educate" the "natives," "savages," or "infidels." Anthropologist Scheper-Hughes writes, "I don't 'like' the idea of clitoridectomy any better than any other woman I know. But I like even less the western 'voices of reason' [imposing their views]" (1991:27). Scheper-Hughes and others suggest that, in arguing that we can make moral judgments across cultures, we are thereby claiming a particular culture knows best and has the right to impose its allegedly superior knowledge on other cultures.

Claiming that we can sometimes judge another culture in a way that has moral force, however, does not entail that one culture is always right, that absolutism is legitimate, or that we can impose our beliefs on others. Relativists sometimes respond that even if this is not a strict logical consequence, it is a practical result. Sherwin writes, "Many social scientists have endorsed versions of relativism precisely out of their sense that the alternative promotes cultural dominance. They may be making a philosophical error in drawing that conclusion, but I do not think that they are making an empirical one" (1992:63–64).

The version of ethical relativism we have been considering, however, does not avoid cultural imperialism. To say that an act is right, on this view, means

that it has cultural approval, including acts of war, oppression, enslavement, aggression, exploitation, racism, or torture. On this view, the disapproval of other cultures is irrelevant in determining whether these acts are right or wrong; accordingly, the disapproval of people in other cultures, even victims of war, oppression, enslavement, aggression, exploitation, racism, or torture, does not count in deciding what is right or wrong except in their own culture. This view thus leads to abhorrent conclusions. It entails not only the affirmation that female circumcision/genital mutilation is right in cultures where it is approved but the affirmation that anything with wide social approval is right, including slavery, war, discrimination, oppression, racism, and torture. If defenders of the version of ethical relativism criticized herein are consistent, they will dismiss any objections by people in other cultures as merely an expression of their own cultural preferences, having no moral standing whatsoever in the society that is engaging in the acts in question.

Defenders of ethical relativism must explain why we should adopt a view leading to such abhorrent conclusions. They may respond that cultures sometimes overlap and hence that the victims' protests within or between cultures ought to count. But this response raises two further difficulties for defenders of ethical relativism. First, it is inconsistent if it means that the views of people in other cultures have moral standing and oppressors ought to consider the views of victims. Such judgments are inconsistent with this version of ethical relativism because they are cross-cultural judgments with moral authority. The second difficulty with this defense, also discussed above, is that it raises the problem of how we differentiate a culture or society.

Second, some defenders of ethical relativism argue that we cannot know enough about another culture to make any cross-cultural moral judgments. We cannot *really* understand another society well enough to criticize it, they claim, because our feelings, concepts, or ways of reasoning are too different; our so-called ordinary moral views about what is permissible are determined by our upbringing and environments to such a degree that they cannot be transferred to other cultures. There are two ways to understand this objection (Sober 1991). The first is that nothing counts as understanding another culture except being raised in it. If that is what is meant, then the objection is valid in a trivial way. But it does not address the important issue of whether we can comprehend well enough to make relevant moral distinctions or engage in critical ethical discussions about the universal human right to be free of oppression.

The second, and nontrivial, way to understand this objection is that we cannot understand another society well enough to justify claiming to know what is right or wrong in that society or even to raise moral questions about what enhances or diminishes life, promotes opportunities, and so on. Overwhelming data, however, suggest that we think we can do this very well. Travelers to other countries often quickly understand that approved practices in their own country are widely condemned elsewhere, sometimes for good reasons. For example, they learn that the U.S. population consumes a disproportionate amount of the world's resources, a fact readily noticed and

condemned by citizens in other cultures. We ordinarily view international criticism and international responses concerning human rights violations, aggression, torture, and exploitation as important ways to show that we care about the rights and welfare of other people, and in some cases these responses have moral authority.

People who deny the possibility of genuine cross-cultural moral judgments must account for why we think we can and should make them, or why we sometimes agree more with people from other cultures than with our own relatives and neighbors about the moral assessments of aggression, oppression, capital punishment, abortion, euthanasia, rights to health care, and so on. International meetings, moreover, seem to employ genuinely cross-cultural moral judgments when they seek to distinguish good from bad uses of technology, promote better environmental or health policies, and so on.

Third, some defenders of ethical relativism object that eliminating important rituals from a culture risks destroying the society. They insist that these cultures cannot survive if they change such a central practice as female circumcision (Scheper-Hughes 1991). This counterargument, however, is not decisive. Slavery, oppression, and exploitation are also necessary to some ways of life, yet few would defend these actions in order to preserve a society. Others reply to this objection by questioning the assumption that these cultures can survive only by continuing clitoridectomy or infibulation (El Dareer 1982). These cultures, they argue, are more likely to be transformed by war, famine, disease, urbanization, and industrialization than by the cessation of this ancient ritual surgery. A further argument is that if slavery, oppression, and exploitation are wrong whether or not there are group benefits, then a decision to eliminate female circumcision/genital mutilation should not depend on a process of weighing its benefits to the group. It is also incoherent or inconsistent to hold that group benefit is so important that other cultures should not interfere with local practices. For this view elevates group benefit as an overriding cross-cultural value, something that these ethical relativists claim cannot be justified. If there are no cross-cultural values about what is wrong or right, a defender of ethical relativism cannot consistently say such things as "One culture ought not interfere with others," "We ought to be tolerant," "Every culture is equally valuable," or "It is wrong to interfere with another culture."

COMMENT

We have sufficient reason, therefore, to conclude that these rituals of female circumcision/genital mutilation are wrong. For me to say they are wrong does not mean that they are disapproved by most people in my culture but wrong for reasons similar to those given by activists within these cultures who are working to stop these practices. They are wrong because the usual forms of the surgery deny women orgasms and because they cause medical complications and even death. It is one thing to say that these practices are

wrong and that activists should be supported in their efforts to stop them; it is another matter to determine how to do this effectively. All agree that education may be the most important means to stop these practices. Some activists in these cultures want an immediate ban (Abdalla 1982). Other activists in these cultures encourage Type 1 circumcision (pricking or removing the clitoral hood) in order to "wean" people away from Types 2 and 3 by substitution. Type 1 has the least association with morbidity or mortality and, if there are no complications, does not preclude sexual orgasms in later life. The chance of success through this tactic is more promising and realistic, they hold, than what an outright ban would achieve; and people could continue many of their traditions and rituals of welcome without causing so much harm (El Dareer 1982). Other activists in these countries, such as Raquiya Abdalla, object to equating Type 1 circumcision in the female with male circumcision: "To me and to many others, the aim and results of any form of circumcision of women are quite different from those applying to the circumcision of men" (1982:8). Because of the hazards of even Type 1 circumcision, especially for infants, I agree with the World Health Organization and the American Medical Association that it would be best to stop all forms of ritual genital surgery on women. Bans have proven ineffective: this still-popular practice has been illegal in most countries for many years (Rushwan 1990; Ntiri 1993; El Dareer 1982). Other proposals by activists focus on education, fines, and carefully crafted legislation (El Dareer 1982; Abdalla 1982; Ozumba 1992; Dirie and Lindmark 1992; WHO 1992).

The critique of the reasons given to support female circumcision/genital mutilation in cultures where it is practiced shows us how to enter discussions, disputes, or assessments in ways that can have moral authority. We share common needs, goals, and methods of reasoning and evaluation. Together they enable us to evaluate many claims across cultures and sometimes to regard ourselves as part of a world community with interests in promoting people's health, happiness, empathy, and opportunities as well as desires to stop war, torture, pandemics, pollution, oppression, and injustice. Thus, ethical relativism—the view that to say something is right means it has cultural approval and to say it is wrong means it has cultural disapproval—is implausible as a useful theory, definition, or account of the meaning of moral judgments. The burden of proof therefore falls upon upholders of this version of ethical relativism to show why criticisms of other cultures always lack moral authority. Although many values are culturally determined and we should not impose moral judgments across cultures hastily, we sometimes know enough to condemn practices approved in other cultures. For example, we can understand enough of the debate about female circumcision/genital mutilation to draw some conclusions: it is wrong, oppressive, and not a voluntary practice in the sense that the people doing it comprehend information relevant to their decision. Moreover, it is a ritual, however well-meant, that violates justifiable and universal human rights or values supported in the human community, and we should promote international moral support for advocates working to stop the practice wherever it is carried out.

NOTES

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1. According to Abdalla (1982:16), in these regions the unusual practice is followed of putting "salt into the vagina after childbirth . . . [because this] induces the narrowing of the vagina . . . to restore the vagina to its former shape and size and make intercourse more pleasurable for the husband."

2. Some authors cite incidences of a very rare operation they call Type 4, or introcision, where the vaginal opening is enlarged by tearing it downward, cutting the perineum (see, for example, Rushwan 1990). It is practiced in Mali and sometimes in Senegal and northern Nigeria (Kouba and Muasher 1985).

3. These laws are often the unenforced remnants of colonial days or governments do not care to apply them. For a fuller discussion of the history of these rituals see Abdalla 1982; El Dareer 1982; Fourcroy 1983; Ntiri 1993; and Ruminjo 1992.

4. In contrast to normative ethical relativism, opponents may take one of several general positions about the meaning of right and wrong. They may hold that rightness and wrongness are the same in some ways but not in others for different cultures; that they depend upon something in human nature, the natural order of things, or the human condition; or that they are absolute and unchanging, either in form or substance, for all people (Holmes 1993).

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