Troubling Issues of Gender and Culture in the General Practitioners’ Consultation Room: a Contribution from the Netherlands.

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Abstract

Background: This paper discusses Dutch general practitioners (GPs) responses to patients, mostly women of migrant background, with health issues related to so-called Harmful Traditional Practices (HTPs) and other troubling issues of gender and culture, that harm the rights and well-being of women. GPs long-lasting personal relationship with their patients and familiarity with their situation make them well positioned to help these patients. Yet, we know very little what troubling health issues related to gender and culture GPs actually encounter in their consultation room and how they deal with them. We suspected, moreover, that their professional ethics offered insufficient moral guidance.

Method: The paper is based on in-depth interviews with fourteen GPs in the Netherlands.

Results: The GPs frequently encountered cases of gender and culture they found troubling, like honor related violence. Some GPs complied with requests for deceitful diagnoses, that were informed by harmful traditions, like requests for virginity certificates, because they believed this was in the patient’s best interest. They therewith compromised their own medical ethics. Their interventions possibly also contributed to the continuation of the harmful practice. On the other hand, respect for their patients’ autonomy made the GPs reticent to intervene, also in case of harmful practices. They required explicit consent or a concrete request from the patient, which might, given the coercive conditions of their patients’ lives, be overdemanding and risk wrongfully withholding help. Bioethics was of little help.

Conclusions: Well-intended medical intervention may contribute to the continuation of cultural traditions that violate women's human rights. Not intervening in harmful issues of gender and culture out of respect for the patient’s autonomy may, however, just as little contribute to the well-being of the patient, because it possibly overstates the patient’s freedom to request intervention. More reflection is needed among medical professionals and in medical education on these troubling issues of gender and culture and their implications for medical intervention.

1. Background

With the increasing cultural diversity of the population in the Netherlands, and in Europe more generally, one might expect health professionals to meet with health issues related to so-called Harmful Traditional Practices (HTPs): cultural traditions of gender inequality that harm the rights and well-being of women. The term refers to a wide array of practices; paradigmatic examples are female genital cutting (FGC), forced marriage and honor related violence. (We prefer the term ‘cutting’ instead of ‘mutilation’, because of the strong moral condemnation contained in the latter term, thus ignoring the meanings the practice may have for women stemming from FGC practicing communities).

We suspected that migrant women might request medical interventions related to HTPs, like a hymen (re)construction or that harmful practices could be at the root of the medical symptom, like depression. In a previous project on suicidality among young women of different ethnic origin in the Netherlands for instance, we met with so-called hidden women. These were women who had migrated to the Netherlands
because of their marriage, usually, to then live in the house of their family in law, under strict surveillance of their mother in law and more or less imprisoned in the house. This had led them to develop depression and eventually to attempt suicide. This previous research was, for the first author, a reason to start this project. I (first author) was alarmed that in many cases this had gone on for years without anybody noticing. They must at least have been seen by their doctor, so I reasoned, why had their general practitioner (GP) not intervened?

We choose to focus on GPs as they are the gatekeepers to health care, which makes them well positioned to help women with health issues related to HTPs and other troubling issues of gender and culture. They normally have a long-lasting personal relationship with their patients and are familiar with their family and social situation. Patients may disclose issues to GPs that otherwise would remain unnamed and GPs can assist the patient as guide and confidential advisor when making choices. This is reflected in the core values of Dutch GP medicine: ‘generalist, patient-oriented and continuous’. We could also imagine that these troubling issues of gender and culture conflict with their personal convictions, and accommodation of health requests related to them to conflict with their professional ethics and wondered whether the latter offered them enough moral guidance in these cases. Therefore, we formulated as research questions: What are the needs general practitioners in the Netherlands encounter related to troubling issues of gender and culture? And based on what bioethical considerations do they respond to these needs?

In our first formulation we used the term ‘Harmful’ traditional practices. Human rights activists had coined the term HTPs to alert the world that some groups endorse cultural traditions that are harmful to women and should be stopped. Yet, this is precisely why others have difficulty with the term: it is overloaded with moral indignation. These ‘others’ included the GPs we approached. We were aware of the sensitivities surrounding the term and had in our text to recruit participants used for instance inverted commas to indicate our critical distance to the term. Yet, one of the first GP’s we interviewed said she had nearly refused to participate because of us using the term. We therefore changed the title of the call into a more general formulation about troubling issues of gender and culture to indicate what we were interested in. That appeared in all its vagueness to be a workable work-description. The GPs subsequently talked about broader issues than those usually falling under the heading of HTPs, yet we welcomed this.

Our findings, we hoped, could be used in medical training, so that future GPs would be better equipped to deal with these cases.

In the next sections we will first present the theoretical background of this study, then describe the methodology and next our findings, based on interviews with fourteen Dutch GPs, followed by discussion and conclusion.

2. Methods

The term Harmful Traditional Practices was developed within a human rights discourse on violence against women. A landmark document, the Convention on the Elimination of All Forms of Discrimination
Against Women, demanded that states take action to eradicate all discrimination against women and to eliminate ‘customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women’. The United Nations’ (UN) Factsheet No. 23, Harmful Traditional Practices Affecting the Health of Women and Children further explained that these practices ‘reflect values and beliefs held by members of a community for periods often spanning generations’ and that ‘despite their harmful nature and their violation of international human rights laws, such practices persist because they are not questioned and take on an aura of morality in the eyes of those practicing them.’[1] While it was recognized that ‘every social grouping in the world’ has such harmful practices, the examples made clear that they were, in particular, a problem in countries of the Global South: ‘female genital mutilation (FGM); forced feeding of women; early marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price.’[1]

Since its inception the term has been an expression of global solidarity - the concept marks transnational feminist activists’ success in getting the subject on the international development and human rights agendas - but also of disagreements between Western and Third World feminists. Western solidarity movements have been accused of using a victimizing discourse that depicts women in developing countries as passive victims of their homogenous cultures. Others pointed out that also countries in the Western world have harmful cultural practices. Doesn’t the Western beauty ideal of thinness force women to starve themselves and how different is women’s deformed feet caused by walking on high heels from Chinese foot-binding practices, so asks for instance Sheila Jeffreys. According to still others harmful cultural traditions are also practiced on men, with male circumcision as a case in point. We took these critiques into account by including comparative questions about labiaplasty and male circumcision in our research. Still, we do not want to disguise that this does not solve the deeper problem connected to the term HTP signaled by Chia Longman and Tamsin Bradley: ‘To de-emphasize either the gender aspect … or the culture-related aspect... would potentially render the concept meaningless’. We are but too aware that this applies also to our description of ‘troubling issues of gender and culture’.

In bioethics there is a modest literature that discusses medical interventions related to HTPs, like hymen (re)construction and male circumcision. The focus of the debate, that sometimes also includes the views of the medical professionals involved, is on the moral acceptability of the intervention. Niklas Juth and Niels Lynøe for instance discuss twelve potential differences between hymen (re)construction and bloodless treatment for Jehovah’s witnesses that could justify offering bloodless operations to Jehovah’s witnesses, but not offering hymen (re)construction. Characteristic for this literature is that it abstracts the relevant normative issues from the case at hand and then discusses how the principles at stake should be applied or, if different principles point in different directions, how they should be balanced to reach a decision. Contextual features of the case are not relevant; they come secondary at best. While this literature has helped recognize possibly relevant values and principles and produced new arguments on how to interpret and balance these, we do not know whether there is any correspondence with how cases
occur in practice and whether these insights speak to the moral dilemmas as they are experienced in medical practice. This was again a reason to research GPs.

The professional ethics Dutch GPs are taught in their medical training is derived from the ‘International Code of Medical Ethics’ formulated in 1949 by the World Medical Association (WMA). The most recent revision was in 2006. The Code explains in general terms the duties of physicians, like to act in the patient’s best interest, to respect a patient’s right to refuse treatment and to abstain from fraud or deception. There is also much reference in bioethical textbooks used in Dutch medical training to the seminal work of Tom Beauchamp and James Childress that starts from the four principles of autonomy, beneficence, non-maleficence and justice. These are reflected in the Dutch Doctors Oath and in the Royal Dutch Medical Association (KNMG) guidelines for doctors. In 2003 the KNMG revised the Oath to reflect the increased recognition in modern medical practice of the importance of patients’ autonomy. One would expect, therefore, that Dutch GPs care much about their patients’ autonomy.

We conducted in-depth interviews, because we were interested in the full context of the cases and because in-depth interviews are best suited to explore the experiences and moral understandings of people. In the course of 2017 we had interviews with fourteen GPs. We searched for GPs who had a longer working experience. As the GP had to have experience with patients of immigrant background, we searched for GPs working in ethnically mixed neighborhoods and aimed for some geographical distribution. The GPs were recruited through our personal contacts, through snowballing and through the GP specialization training of an academic hospital in Amsterdam. The hospital sent our call to the GPs and when they responded positively, we contacted them directly.

The adjusted title of the call was: Research General Practitioners on Requests for Help at the Interface between Culture and Gender. Subtitle: How do you deal with emotionally charged themes like honor and virginity, homosexuality or forced marriage? The GPs were promised confidentiality and all signed an informed consent form. The interviews lasted approximately between 1–1.5 hours and took place in the office of the GP or at their home address and were recorded. We asked the GPs whether they had had cases in their practice related to gender and culture, like the ones mentioned in the call, they found troubling. The GPs usually had so much experiences, that our role in the rest of the interview was in most cases limited to asking for clarification. The interviews were transcribed and sent to the GPs for approval. Next, they were analyzed with the help of Atlas-ti. In a first round we analyzed which troubling issues of gender and culture the GPs encountered coded them accordingly (e.g. honor related violence) and in a second round we zeroed in on their responses and acting decisions. To secure intersubjectivity we had several interviews coded by both of us and then compared our coding. In case of a difference in coding, we discussed this until consensus was reached. Lastly, a concept version of the paper was sent to all participants. We did not receive negative feedback; those GPs who responded said they had read it with interest.

3. Results
3.1 Who are the GPs?

In line with reality – GP is rapidly becoming a women’s profession in the Netherlands – ten GPs are female. The majority is of native white Dutch origin, one is Jewish Dutch, one is from Aruba (Dutch Antilles), one is of white British origin and two GPs are of Turkish origin. Most of them are already GP for a very long period and are holding practice in the same ethnically mixed neighborhood. The average time they are holding practice is twenty-three years with one GP holding practice for two years, and on the other end two GPs practicing for thirty-nine years. Therefore, they sometimes have several generations of one family as patients. Their patients of migrant background initially were labor migrants, usually of Turkish or Moroccan background and colonial migrants like people from the Dutch Antilles and Surinam, and later also people with a refugee background. Six GPs have their practice in the big cities, as these are the places where the majority of people of migrant origin in the Netherlands live. Still, also in smaller towns we found GPs with patients of migrant background, because they were recruited for a nearby industry or a refugee center was established nearby. Thus, five participants hold practice in smaller towns.

3.2 The GPs experiences with troubling cases of gender and culture

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Overview of the main cases mentioned by the GPs.
The troubling cases of gender and culture that were mentioned most often by the GPs are female genital cutting (11 GPs), requests for virginity certificates (10 GPs), honor related violence (10 GPs), and forced marriage (9 GPs).

When mentioning female genital cutting the GPs meant they had adult patients in their practice who had been cut in their youth. All forms of FGC are forbidden in the Netherlands and doctors are obliged to discuss the issue with women stemming from risk countries and when they suspect there is risk of FGC to take place, to report this to the authorities. Nevertheless, the GPs rarely had conversations with patients who are genitally cut, as the women were aware that FGC is forbidden by law and denied they had any intention to have their daughters genitally cut. Neither did the GPs discuss other issues known to be related to FGC, like physical and psychological complaints, with their patients. This probably means that women, who are genitally cut, find it difficult to discuss health issues related to this with their GP, as is confirmed by other research.

The distinction between arranged and forced marriage, and with that between voluntary and forced marriage, is always tenuous. Even in Dutch culture, where the romantic love marriage is the ideal, parents may try to influence their children's partner choice. We have classified as ‘forced marriage’ all those cases in which the patient had explicitly indicated that she – all cases of forced marriage concerned women – did not want this marriage. One GP had several patients who were forced to marry the man who had raped them. The arranged marriages that ten GPs mentioned also involved considerable pressure from the family on the daughter, and in several cases the son, to comply. Usually they were marriages within the family (often cousin marriages, mentioned by eight GPs) and sometimes with a big age difference (five GPs mentioned this).

The background to honor related violence was that the victim was suspected of transgressing codes of proper female sexual conduct. The cases of honor related violence included threats of violence, but patients also came with injuries and two GPs had lost patients who had become the victim of an honor killing. Six GPs had had patients who were repudiated by their husband and families after they had ‘confessed’ that in the past they had been raped. Requests for virginity certificates were made by young women, often accompanied by their mother, because the daughter's reputation was at stake. Five GPs had experienced that a young unmarried woman was forced to have an abortion and one that the woman was forced to give up her child for adoption. Hymen ‘repair’ refers to cases in which young women who had had premarital sex asked for surgery to (re)construct their hymen. Two GPs had had male patients, whom they suspected struggled with their homosexuality and one GP told about patients of hers, who had had an arranged marriage to, as she suspected, a homosexual man.

Beside the named practices in the table, a variety of other, unclassifiable, cases were put forward by the GPs. Several GPs had had female patients who were send back against their will to the country of origin. Many cases were expressions of unequal gender relations, like a wife who had caught a sexually transmitted disease (STD) from her husband but did not dare to confront him with that. Also, GPs referred to cases of young women who were expected to fully shoulder the informal care for relatives in need,
which led to complaints of overburdening, but also meant that they could not continue their education or start a family of their own.

A preliminary conclusion we can draw is that the majority of cases is related in one way or the other to (the regulation of) sexuality.

In many cases the GP’s felt there was little they could do. Patients disappeared from their practice and only later they learned what had happened. When patients did mention their worries to them their usual course of action was to offer a listening ear and if they were open to it give some advice or organize help. Still, some GPs wanted to do more, and did more, but then crossed the boundaries of their professional ethics, whilst others were kept back, or restrained themselves, by their professional ethics, by their respect for their patients’ autonomy in particular, from acting. In the next two sections we’ll discuss these two issues.

3.3 In the name of patient well-being all is allowed?

The GPs were very committed to their patients and also in cases of gender and culture they found troubling wanted to help in whatever way they could. GP1 for instance told that in a case involving honor related violence she was asked by a young female patient to pick her up from the pharmacy. The young woman was expected at home hours before and now did not dare to go home because of the sanctions she feared. The family was familiar to the doctor with family violence. So, the doctor picked her up, brought her home and lied to the family that she was ill and had to go to bed with some painkiller. GP2 told she had a woman in her practice who asked for contraceptives without her husband knowing. When later the couple came to consult her, because the woman did not get pregnant, she avoided a straightforward answer by explaining that there can be many reasons why women do not become pregnant. Yet, their acting in the best interest of the patient was not without moral dilemmas. This became most clear in the issue that the GPs experience as the morally most trying, when they were asked to establish a patient’s virginity. Ten GPs had had requests for virginity testing, and six had complied. The context was usually that the family pressured the young woman to have her virginity confirmed because there were doubts about her chastity. There were threats of sanctions and the doubts could be an obstacle to get married. Some doctors had in some cases actually performed a vaginal examination, although they knew of course that technically there is no necessary relationship between the status of the hymen and virginity and hence it is impossible for doctors to establish whether a woman is still a virgin. More common however was that they sought to have a private conversation with the young woman to hear from her what was the matter and what she wanted, and then to write a virginity certificate or if the family settled for that, to verbally transmit the result of the ‘examination’. The other four GPs had refused, because they did not consider this as part of their job or believed that by complying they would strengthen the sexual morality they rejected or that it might pave the way to other undesirable things, like a marriage with a husband the young woman did not want (the man demanded proof of his bride’s virginity).
The World Health Organization (WHO) has declared in 2018 virginity testing a harmful practice. The interviews took place in 2017, yet none of the GPs referred to the testing as a harmful practice. What then bothered them? Was it that the requests for the testing were made under pressure and coercion from the families? Normally, an intervention needs the patient’s voluntary consent. Yet, if women are forced to ask for an intervention, this condition is not met. Yet, the GPs did not seem to notice the problem that the request cannot be considered an autonomous choice. Another reason for their moral distress might be that they were responding to a sociocultural instead of a biomedical problem. The notion that patients’ needs can be social in nature is well recognized by the first principle of the Constitution of the WHO: ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’ Yet, as Pablo De Lora pointed out, the idea of medical need is still a matter of controversy, as shows for instance from the battle between insurance companies and patients over what treatment is medically necessary. In the Netherlands the importance of experiencing social acceptance and positive self-worth for a patient’s well-being is accepted as justification for other non-medically indicated interventions, like surgery on children with flap ears, that is covered by in the optional package of many health insurances. On the other hand, while being circumcised is important for social acceptance in Jewish and Muslim communities, male circumcision for religious reasons is currently only part of the optional health care package of one insurance company. Writing out a virginity certificate undoubtedly promotes social acceptance, but less obviously so positive self-worth, and whether it prevents harm to the woman in question is questionable given the WHO’s statement. Yet, what bothered the GPs was not that they were acting on a social problem instead of a physical complaint. Their problem was that they were falsely diagnosing a condition. When they wrote that they could not establish that the young woman has lost her virginity, they were well aware these are ‘diplomatic certificates’ as Juth and Lynøe [14] name them, as the double negation makes that technically they are not lying, but that did not ease their discomfort. GP13 explained why, still, he complied with the request: ‘I take them under my protection by saying that I cannot see that the hymen is ruptured. ... I go along in (it) because if I don’t, it is a big problem for them. ...’ GP3, herself of Turkish origin, similarly stated: ‘You are a social worker. You try to be non-judgmental. Sometimes you have to trespass certain boundaries, or, you are not obliged to, but you do what is beneficial for the patient. To protect the patient, you do sometimes things you think of as bullshit.’ GP14 therefore called the certificate ‘the nonsense certificate’.

Hence, the GPs wanted to act in the best interest of the patient, but when this came down to engaging in deceit, they trespassed their private and professional moral boundaries. This is particularly so when it concerned virginity tests. While the GPs did not see it as a harmful practice, the WHO does. Doctors performing virginity tests would hence, according to WHO standards, violate their patients’ human rights and doctors suggesting they performed the test, would contribute to the continuation of a tradition that violates women’s human rights.

### 3.4 Non-intervention in the name of autonomy?

Autonomy has become a very central principle in biomedical ethics. The GPs also found it very important to respect the autonomy of the patient. Illustrative is their acting regarding unwanted marriages.
Sometimes patients visited them because of health problems caused by the accompanying distress, sometimes they came with a direct request for help. The practice usually is that a young woman who is raised in the Netherlands comes to tell the doctor that she is going to marry a man from ‘the village’ – that is the village in the country of origin where the family stems from. They are not forced to marry these men, but as GP1 called it ‘are being massaged’ for years into marrying them. GP3 and GP4 had also men who had problems with their marriage being arranged. GP4 told about a male patient of hers: ‘In the years before his mother died – his father had already passed away – he had many stress-related complaints that I could not pin down. Later, he told me that these complaints were because he was so unhappy in his marriage, but that he had to go through with it for his mother. … He had never wanted this woman … And when the mother died, the man told his wife that he wanted to divorce.’ GP3, herself of Turkish origin, explained that generally the children are afraid to go against their parents’ will, because they fear they will lose all contact with them. Her experience, however, was that in most cases the parents later come to terms with it. That is what she always tells the young people together with the message that they have to decide for themselves and not consent to this marriage only because the parents want it. From what GP2 related about a woman of Turkish origin, it becomes clear that, contra to GP3’s experience, the family can react badly if a family member goes her own way. The young woman ran away from home with a Turkish boyfriend to show up only three weeks later. She married the young man, but it turned out that he maltreated her. GP2: ‘Father and brothers never wanted to see her again and that is still the case now, six years later … and the mother and her sister couldn’t bear to watch it. And they were very angry at me at that time, that I did not do anything, but I did not know what I should do. … They were desperate. And now … mother and sister secretly have contact with that girl and the father more or less knows this, but the brothers absolutely not, because they are still furious with her, because the honor is so tarnished by what she did…. The daughter [at home, xx/yy] is even more in a fix [than the parents], because she sees her parents suffering, whom she loves very much, and about whom she feels very clearly that they cannot act otherwise, and on the other hand she says “It is terrible what is happening, we have to help my sister”.

The maltreated sister did not dare to divorce, because she had harmed her family already so much by her dishonorable behavior, that she could not on top of that divorce. The GP’s intervention was that she started conversations with the parents and the daughters, which is her normal practice, to offer a listening ear and give some advice. Apparently, the family expected her to do more, but she did not know what to do.

The Dutch Society of Medicine, KNMG, has a code on family violence, that includes FGC, honor related violence and forced marriage, that makes clear that in some cases the patient’s choices may be overruled. When an adult victim refuses to give permission to report the case, if this is because of the dependency relationship with the perpetrator, including fear for repercussions, this does not count as a free choice, and the code prescribes to report the case to stop further bodily or mental harm.

Nevertheless, the GPs were reticent to intervene. They felt it as an intrusion in other people’s lives that was only justified if patients explicitly consented with or requested the intervention. As GP1 explained: ‘It is a meddling in other people’s lives, about which you ask yourself ‘Is this my role?’ and ‘Do I know enough about it’ (their culture xx/yy). Her general viewpoint was: ‘It is not up to me to interfere in people’s lives.'
Except when they ask me to, then I might do it, but not of my own accord. It is up to people themselves to live their lives. And in my eyes young people are sometimes the victim of their parents’ culture, but it is also up to them to struggle out of that. And if they cannot do that, then they can’t, and if I do it (for them) then afterwards they are still not able to. So, my idea is that one has to have patience and believe that the next generation will do it differently.’ It may be that their duty of professional confidentiality restricted their room for intervention, as discussing the problem in the family or calling in professional help breaks confidentiality and requires the consent of the patient. Yet, none of the GPs mentioned this argument. They appeared driven primarily by the wish to respect the autonomy of their patients. This led them to expect their, mostly female, patients of migrant background to explicitly consent with or request for intervention before they would act. Yet, given the oppressive family circumstances of these patients this might be overdemanding, as is also suggested by the KNMG code on family violence. The outcome is non-intervention.

3.5 Comparison cases: labiaplasty and male circumcision

When it comes to Dutch patients, usually young women, who ask for labiaplasty, the GPs usually entered a conversation to discourage the patient, because after inspection almost always it turned out that it was for cosmetic reasons only. They felt little inhibition to speak their minds towards the patient. This contrasts sharply with their moral rule to refrain from judgment when it concerns patients of migrant background. GP1 said for instance about the perpetrators of honor related violence: ‘I have seen those boys when they were little, and when they grow up they start kicking their sister to pieces. That is so hard to accept, but this is how they are raised, this is what you have to do, how you are a good son and a good brother. So, to only despise them is too easy.’

If not medically indicated, male circumcision is not covered by the health insurance. Most families, therefore, go directly to specialized private clinics. Still, GPs could raise the issue with them, but they refrain from it. GP13, male, expressed what the other GPs too feel: ‘Male circumcision is of a different order than female circumcision, less mutilating and far-reaching than for a girl. And it feels like it is a hopeless task, I must say.’ With this he meant that it as a practice that is so commonly accepted by their Islamic and Jewish patients that a conversation has no use. Yet, the GPs also experienced it themselves as a non-controversial subject. GP1, herself Jewish, considered it is up to the Muslim or Jewish communities, not to the GP to make an issue out of it. Only GP3, herself of Turkish origin, was outspoken: ‘It is not in the Koran that boys must be circumcised. It is because once upon a time Mohammed has done it, it is a cultural thing, not a religious thing.’ Still, she also said: ‘It is so deeply rooted … it is not accepted … You can better have it done when they are a child then that they feel cast off or not accepted, because that subject is really holy, male circumcision, you may not touch that. The same with Jewish people. It is not open to discussion.’ And so, she too, refrained from raising the subject with her patients.

4. Discussion

This study aimed to investigate what health issues related to HTPs and other troubling issues of gender and culture GPs encounter in their practice. Its second aim was to discover how GPs respond to these
issues and by analyzing how they reach a decision on intervention to find out if bioethics and multicultural philosophy offers them enough moral guidance.

Regarding the first aim, the GPs had many experiences with troubling issues of gender and culture. Most of the cases they mentioned are of a social nature and are related to the regulation of sexuality: marriage practices, requests for virginity certificates, hymen (re)construction, forced abortion or giving up the child, non-acceptance of homosexuality, FGC and honor related violence. Here, one should bear in mind that the GPs reports on their encounters with troubling issues of gender and culture were of course spurred by our questions and not representative of what goes on in migrant families more generally. Had we focused on issues of native Dutch patients that troubled them, we would probably also have heard a lot of, albeit different, misery. This is intrinsic to the role of the GP as the gatekeeper of health care: social problems that exist in society enter his or her consultation room the first.

The GPs responses were motivated mainly by a desire to act in the best interest of the patient and to respect the patient's autonomy. Their actual intervention was, however, rather limited. Their help consisted mainly of offering a listening ear to the patient and to help her (or occasionally him) find out what she herself wanted. Often, there was little they could do, because it was only after the fact that they learned that a patient was sent back to the country of origin or had become a victim of honor related violence. Yet, it was also their respect for their patients' autonomy that kept them from acting. If the patient agreed to it, they also discussed things with the parents or husband to persuade them to act otherwise or they organized help from other professionals. Yet, they would never do so unsolicited. Their line of conduct was to only intervene when the patient consents and preferably when there is a concrete request, often resulting in non-intervention. This is probably the answer to the question that motivated me (the first author) to do this research: the abuse that led women to attempt suicide could go one for so long, because the women did not explicitly ask for help.

While their respect for the patient's autonomy made GPs refrain from intervention, the opposite also occurred. In their desire to protect the patient and to prevent harm, GPs also intervened and complied with requests that were done under pressure and therefore could not be considered as an autonomous choice, like requests for a virginity certificate. The GPs were well aware that the patients who came to them with troubling issues of gender and culture live socially embedded lives, more so than their native Dutch patients. Others have an important say in important life decisions, like choosing their marriage partner. Nor are cultural norms easy to ignore. The GPs understood that their patients feared being shunned when they wanted to divorce or feared physical violence if they were believed to have transgressed norms of proper sexual conduct. This is why some were willing to lie on behalf of the patient. This created the dilemma that they wanted to act in the best interest of the patient, yet refrain from deceit. Whilst falsely diagnosing a condition is probably not compatible with any guidelines for proper medical conduct, the GPs could at least be given a platform to reflect on their moral dilemmas around compassion with their patient, deceit and the limits of medical intervention. Well-intended medical intervention may contribute to the continuation of cultural traditions that violate women's human rights as the case of virginity testing and issuing virginity certificates illustrates.
Considerations regarding autonomy played a central, yet problematic, role in the GPs decision-making. Does bioethics offer a way out? Debates in biomedical ethics on autonomy center on the question how to act as much as possible in accordance with the autonomy principle in cases where the patient is not yet, or no longer able to full autonomy. The Dutch Association of Pediatrics for instance advocates that in cases of euthanasia on children not their calendar age is decisive – up to twelve years of age they have no say in the matter – but their real capacity to give informed consent, like is the situation in Belgium since 2014. Another example is the resolution adopted in 2013 by the Council of Europe on ‘Children’s Right to Physical Integrity[11] that recommends not to carry out male circumcisions before the boy is old enough to be consulted. Yet, in the cases of gender and culture that the GPs encountered the problem with autonomy is of a different nature. Here, it is social pressure and coercion, that compromises an adult patient’s autonomy. The great importance given in modern medicine to patient autonomy, and with that to informed consent as a condition for intervention, sits uneasily with the realities of these patients. It brings the risk that GPs wrongfully withhold help. Yet, to comply with requests, that are informed by harmful traditions and obviously made under pressure and coercion, like requests for virginity certificates, is also problematic. This is not only because medical professionals are supposed not to engage in deceit, but also because the request is difficult to perceive of as an autonomous choice and the intervention can contribute to the harmful practices’ continuation. Current debates in bioethics do not address these moral problems occurring in the GPs medical practice. Further reflection is needed on autonomy under coercive conditions and its implications for decisions on medical intervention.

The labiaplasty case suggests that when it comes to requests for medical intervention informed by Dutch culture, the GPs do not feel the same inhibition to make judgments as they feel when it concerns migrant cultures. It may be that they believe Dutch women have more freedom to choose or that they are inclined to a cultural relativism, that avoids judgment of other cultures. The only exception is GP3, herself of Turkish origin, who spoke her mind irrespective of cultural context. Male circumcision is almost a non-issue for the GPs. This is surprising given the intrusiveness and irreversibility of the procedure that has made male circumcision a contested issue in Europe. It suggests that the, mainly legal, debate over male circumcision has as yet not reached Dutch general practice.

This study is, to the best of our knowledge, the first one that broadly investigated what health issues related to HTPs and other troubling issues of gender and culture GPs encounter in their practice and how they deal with these. We interviewed fourteen Dutch GPs. This points to an obvious limitation. The findings may not be generalizable. Moreover, we spoke with GPs only. The voices of the patients are missing. More research is needed, among GPs and other health professionals, but in particular among the women concerned on their perceptions of and experiences with medical intervention related to HTPs and other troubling issues of gender and culture.

5. Conclusions

The GPs that were researched in this study had frequent encounters with patients, mostly women of migrant background, visiting them with needs related to HTPs and other troubling issues of gender and
culture. These were mostly related to the regulation of sexuality. While the GPs wanted to help these women in every way possible, their actual intervention was limited. Their respect for their patients’ autonomy made the GPs reticent to intervene when a patient was a victim of harmful practices. They required explicit consent or a concrete request from the patient, which might, given the coercive conditions of their patients’ lives, be rather overdemanding and risk withholding help when needed. Yet, some GPs also complied with requests, informed by harmful traditions and obviously made under pressure and coercion, that did not meet minimal conditions of autonomous choice. This was because they believed that with the requested intervention, often to falsely diagnose a condition, they were acting in the best interest of the patient. Yet with that they compromised their own professional ethics and possibly contributed to the continuation of the harmful practice in question. More reflection is needed among medical professionals and in medical education on these troubling issues of gender and culture, that violate women’s human rights, and their implications for medical intervention.

**Abbreviations**

CCMO
Centrale Commissie Mensgebonden onderzoek (Central Committee on Research Involving Human Subjects)

FGC
Female Genital Cutting

FGM
Female Genital Mutilation

GP
General Practitioner

HTP
Harmful Traditional Practice

KNMG
Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (Royal Dutch Medical Association)

STD
Sexually Transmitted Disease

UN
United Nations

WMO
Wet medisch-wetenschappelijk onderzoek met mensen (Medical Research Involving Subjects Act)

WHO
World Health Organization

WMA
World Medical Association
Declarations

Ethics approval and consent to participate:

The Dutch Central Committee on Research Involving Human Subjects (CCMO) executes the Medical Research Involving Subjects Act (WMO). This article is based on interviews with professionals, which according to the CCMO do not fall under the operation of the law. https://english.ccmo.nl/investigators/legal-framework-for-medical-scientific-research/your-research-is-it-subject-to-the-wmo-or-not Accessed 30 September 2019. All participants signed an informed consent form.

Consent for publication:

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Author’s contributions:

SS made the study design. The interviewing was shared between the authors. CD transcribed the interviews and coded them under supervision by SS. The analysis and interpretation of data were shared. The manuscript was mainly written by SS. All authors read and approved the final manuscript.
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Author’s information:

For now we left this section open, because the info could reveal who we are.

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