On *becoming autonomous* and "coercive cultural acts": a reply to Max Buckler

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In response to my suggestion that there should be a universal age at which people should be legally considered able to make decisions to alter their genitalia (1), Max Buckler argues that older children and teenagers should have their autonomous-decision making capacities assessed individually and be treated on a case-by-case basis when it comes to such procedures (2). He claims that there is an important difference between "coercive cultural acts" and those sought out by older children for their "own desire"(2). Buckler also asks for clarity on the following:

1) What practices count here as "genital cutting and/or modification?"
2) When does a child in the moral sense become a sufficiently autonomous "adult?" (2)

In clarifying my position in response to these questions (in reverse order), I also spell out my objection to case-by-case treatment when it comes to genital modification practices for children. A differentiated policy of this kind would presumably involve assessing individual children's capacities for decision-making using externally created and judged criteria, like Gillick and Fraser competency assessments (3). Buckler rightly points out that some individuals may develop the internal tools to make decisions with a lasting impact before they are legally considered to be adults (2). But, if states were to abandon a legal age threshold for particular rights and instead adopt a competence/autonomy threshold and treat each person on a case-by-case basis, then there would probably be cultural discrimination in the assessment of which teenagers were decided to be sufficiently autonomous,[1] and there would likely be *adults* who *would not* be considered sufficiently autonomous to make the kinds of decisions under discussion (4,5). It seems obvious that some fourteen-year-olds have developed better decision-making capacities than other fourteen-year-olds, but given the differences in human development due to diverse internal and external conditions,

[1] This claim is based on the fact that in western liberal societies there are currently morally unjustifiable differences in legal and medical assessments of women's consent-making capacities depending on their cultural background, where women from marginalised groups are often assessed as less capable of giving informed consent than women from dominant groups (19,22,24–27,29).

and given the fact that the yardstick for what counted as sufficiently autonomous decision-making skills would be informed by the behavioural norms, values, and expectations of dominant groups in western liberal societies, it is highly likely that young people from marginalised groups would be treated unfairly compared to their dominant group counterparts (6–8). Further, some fourteen-year-olds may score higher than many twenty-five and thirty-plus year olds. Requiring people to demonstrate sufficient autonomy on a case-by-case basis – as judged by external observers – is a pathway to rights exclusions that could amplify discrimination against already marginalised cultural groups and consolidate biases against adults who demonstrate different kinds of decision-making capacity.

On *becoming autonomous*

There is an awful lot at stake when seeking to articulate what autonomy is and who has it when. Whether or not a person is assumed to be autonomous has bearing on how they are treated legally, socially, medically, economically, and politically. Differentiating people based on their presumed autonomy (or lack-thereof) has historically been an effect and manifestation of state sanctioned injustice. For instance, denying political rights to women and people of colour (4,5,9). As such, differentiating children and adults based on their autonomy capacities needs careful consideration. The consensus in liberal thought is that children are different from adults when it comes to autonomy. Children are conceived of as not autonomous, or not yet autonomous, or pre-autonomous, or as having the potential for autonomy, and this differentiation has an impact on the rights that are attributed to them theoretically and in practice (4,5,9–11).

To account for the differences between children and adults, and to articulate the moral need for certain protective rights for children, I characterise children as being in a dialogical process of developing their capacities for exercising autonomy, making them distinct from entirely non-

autonomous entities (5). I emphasise the difference between adults and children in two key senses that are important for the rights they hold:

1) Children's relative dependency and physical vulnerability (5,12);
2) Children's condition of *becoming autonomous* (5).

The broad category of *becoming autonomous* is dynamic and includes various stages of development. New-borns, toddlers, and teenagers are generally at different phases in their development of autonomy; I take this to be empirically obvious and uncontroversial, exceptions notwithstanding (3,5,11,13,14). When an infant cries and a parent responds by picking them up for a cuddle they begin to learn about how the world responds when they act; when a toddler throws a ball at a wall and the ball bounces back towards them they are learning about the relationship between their actions and the external world; when a primary schooler is asked to choose between several lunch options they are learning to express preferences and that their choices can have positive consequences for them; when a teenager stays out later than they are supposed to and so their parents do not let them out the next evening they are learning that there can be negative social consequences to their actions. These examples involve different dimensions and levels of complexity, but they all fall within the broad experiential archetype of becoming autonomous, which begins when infants start to make sense of how they affect and are affected by the world (5). Brian D. Earp has suggested that there are differences in the stages of a child's development of autonomy and argues that we should think of children's development of autonomy as being on a "spectrum", wherein infants have "almost no autonomy" and "older teenager[s]" have "almost full autonomy, as defined by what is characteristic for adults" (11). This idea is normatively compatible with my approach to the child's dialogical cultivation of autonomy, but while Earp in places allows some scope for older teenagers to consent to genital modification (15), I commit to the idea that there should be a universalised age at which people are legally permitted to make decisions to permanently alter their genitals and sexual anatomy for medically unnecessary reasons.

I cannot stipulate a precise moment at which every child becomes an autonomous adult in every sense, neither can I be sure that every adult I meet is always acting autonomously (nor even, that I am always acting autonomously) – autonomy is complex and multidimensional, cannot be simply switched on, and it cannot be observed externally (8). Rather, becoming autonomous is a process that every person goes through in unique dialogue with their diverse internal and external conditions, but we should assume that the adults we meet are equally able to make informed decisions about their lives (5). There are three key aims of stipulating an age at which people should be legally permitted to have genital modification procedures: to guard against dominant group biases towards the familiar and against "the foreign" when it comes to determining who is and who is not capable of consenting to genital modification (6–8); to protect younger people from making harmful and/or significantly life altering decisions that they do not yet fully understand; and to protect adults from being *excluded* from particular rights and possibilities on the basis that they have not demonstrated or lived through certain externally observable autonomy criteria, such as those involved in Gillick and Fraser competency assessments (3).

On "coercive cultural acts" and practices

The concept of the child's right to bodily and genital integrity that I endorse refers to all practices that are medically unnecessary[2] and informed and maintained by the norms and values of the child's sociocultural context. The right includes prevention of modifications and alterations induced by growth hormones and puberty blockers as well as those caused by cutting, repositioning, removing,

[2] There is not enough space to provide a lengthy explanation of what counts as medically necessary/unnecessary – and it is almost certain that there will be disagreement within the medical community. But I should state for clarity regarding my position in the relevant debate, that I would include terminating an unwanted underage pregnancy as "medically necessary care" (30).

and stitching (5). For instance, all forms of intersex genital and bodily modification that is not necessary for the body's healthy functioning (16), including growth hormones and interventions on sexual anatomy that is not necessarily their genitalia, should be prevented until the person is a particular age and can decide whether they want their sexual anatomy altered (15,16).

Buckler distinguishes practices conducted by diverse cultural groups: "coercive cultural acts performed without the recipient's input, often without their knowledge and without regard to any objection they may raise….[and]… practices that could be described as self-impacting, in which the impacted individual's change of bodily state is not clearly enacted for the sake of another individual's desire, but rather for their own" (2). The idea Buckler is pushing here is that there is an important moral difference between "cultural" genital cutting that is enforced on young children's bodies, and "self-impacting" genital modifications sought out by older children for themselves. This distinction matters because the liberal consensus is that unjustifiable and non-consensual harmful actions affecting others should be prohibited, but self-affecting or consensual other-affecting actions that may be considered harmful should not – the individual should be permitted to make decisions that contain an element of risk of harm to themselves(12,17,18). But, the distinction between "coercive cultural acts" and "practices that could be described as self-impacting" is hasty, oversimplified, and not as easy to maintain as it seems at first blush. It would be interesting to know which practices count as "coercive cultural acts" on Buckler's view – I hold intersex genital cutting and modification to be just as culturally informed as male and female child genital cutting practices (5,16,19–21). Parental decision-making when it comes to intersex genital modification is always susceptible to influence by available sociocultural norms and the information provided by the relevant professionals.

Any autonomy exercised by an adult has been acquired over a very specific period of time, and every autonomous adult has been a child who developed and finessed their capacities for autonomy throughout their childhood in dialogue with the available norms and values. The autonomous

individual right-bearer is inseparable from the child who is becoming autonomous in this respect; they will inevitably have had their autonomy and preferences "scribbled on" by the main norms and values shared and held by their adult carers and within their sociocultural contexts (18). This means that dominant *and* marginalised group members' preferences and decision-making capacities are affected by the norms and values of their respective contexts which will inform their assessment of the decision-making capacities of others. Decisions and contexts that are familiar to the people assessing the competencies of others will likely be viewed as more autonomous than the decisions and contexts that are less familiar (7).

Conceiving of the relationship between the child's period of becoming autonomous as such implies that the state should respond to child genital cutting practices and those chosen by adults for their own bodies (such as, women choosing Female Genital Cutting (FGC) or Female Genital Cosmetic Surgeries (FGCS)) in the same way. *All* adults are assumed to have undergone a period of becoming autonomous in which their preferences are influenced by the norms and values of their cultural context, whether they are from dominant or marginalised cultural groups. It is well established that there is political and moral inconsistency in contemporary laws concerning *adult* genital cutting and modification, that often falls along cultural lines (7,8,22–27). FGCSs are permitted and packaged within a narrative of "choice" and "self-improvement", but FGC sought by adult women from marginalised groups is prohibited and packaged within a narrative of "coercive cultur[e]" (22,24,26,28). This sort of legal inconsistency would likely be reinforced with a case-by-case policy for deciding which teenagers are sufficiently autonomous to consent to genital modification and which are not, because the dominant groups in western liberal societies continue to interpret genital cutting and modification by marginalised groups as "coercive" and non-autonomous, *even when* sought by adult women (22,24,26). The position I maintain, is that all medically unnecessary child genital cutting and modification should be prohibited across groups, but once a person becomes a legal adult, whatever their cultural background and provided they are not being physically coerced

into the procedure, they should be permitted to undergo genital cutting and modification of their choosing.

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