

Harmful Cultural Practices in the Consultation Room: Dutch General Practitioners' Views and Experiences

Sawitri Saharso (✉ s.saharso@vu.nl)

VU University Amsterdam <https://orcid.org/0000-0002-9729-0467>

Carlijn Dekker

University of Amsterdam

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Abstract

We discuss Dutch general practitioners' responses to patients, mostly women of migrant background, with needs related to Harmful Cultural Practices. Our aim was to discover whether they encounter these kind of health issues and how they respond. We suspected that the patients concerned would not get the care they needed. We found that there is reason for concern, as based on general practitioners' own accounts we conclude that notwithstanding their great commitment to these patients they were disinclined to intervene, because they were cautious to judge other cultures and because they may have over- or underestimated the women's autonomy.

Introduction

How do general practitioners (GPs) respond to patients, mostly women of migrant background, with health issues related to so-called Harmful Cultural Practices (HCPs)? HCPs are cultural practices that harm the rights and well-being of a person, because of that person's gender. They are grounded in traditional cultural gender norms and unequal power relations. The majority of people subjected to these practices is female (UN, 2014). The term refers to a wide array of practices; paradigmatic examples are female genital cutting (FGC), forced marriage and honor related violence. In 2018 virginity testing was added as a harmful practices by the World Health Organization (WHO). Whilst HCPs were believed to exist primarily in countries in the Global South, due to migration these have also emerged in societies in the Global North, including the Netherlands. Health professionals have encountered health issues related to HCPs, because migrant women have requested medical interventions related to HCPs, like a hymen reconstruction or a virginity certificate (Crosby et al., 2020; Van Moorst et al., 2012). Also, harmful practices have found to be at the root of the medical symptom, like depression and suicidality. In a previous project on suicidality among young women of different ethnic origin in the Netherlands, we found that there was a relationship with harmful practices. Their lives were overly constrained by gendered cultural demands. They were forced to marry, used as a maid by their in-laws, had no control over their own fertility, and were often confined to the house (xxx, 2016). This had led them to develop depression and eventually to attempt suicide (see also Montesinos et al., 2019). 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 GP not intervened? I suspected that the GPs had not recognized these cases or had otherwise inadequately responded. We were also interested in the role of GPs professional ethics, as it would be a reason for extra concern if doctors did not respond adequately because of the ethics they were supposed to follow. Surprisingly, given the urgency of the matter, this has not been researched. Therefore, our aim was to find out what needs, if any, related to HCPs GPs in the Netherlands encounter and how they respond to these needs, which might possibly explain why the abuse, noticed in the earlier research, could go on undetected for so long.

Before we continue to describe the methodology and findings, we will first explain in the next section our position regarding the term HCPs, that influenced our research design, and discuss the relevant literature.

Background

Since its inception the idea of harmful cultural practices 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 (Longman & Bradley 2015). Practices considered harmful by cultural outsiders, are usually not considered as harmful by those exercising them. Solidarity movements from the Global North have been accused of using a victimizing discourse that depicts women from the Global South as passive victims of their homogenous traditional cultures (Mohanty, 1991). Others have pointed out that also countries in the Global North have HCPs. Doesn't the Western beauty ideal of thinness force women to starve themselves, so asks for instance Sheila Jeffreys (2005, pp. 128-148). According to still others harmful cultural traditions are also practiced on men, with male circumcision as a case in point (Darby & Svoboda, 2007). Responsive to these critiques the Committee on the Elimination of Discrimination Against Women (CEDAW) has broadened its definition so as to include also Western practices and men as possible victims (UN, 2014). In our approach we also work from this broader understanding.

A first framework to understand GPs decision-making on HCPs is their professional ethics, that should guide their actions. The professional ethics Dutch GPs are taught 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. In medical ethical textbooks used in Dutch medical training (e.g. Bolt, Verweij & van Delden 2010; Ten Have, Ter Meulen & Van Leeuwen 2009) there is also much reference to the seminal work of Tom Beauchamp and James Childress (1994) 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.

There is also a legal framework and guidelines regarding HCPs that set the boundaries of medical intervention. 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. The Dutch Society of Medicine, KNMG, has a code on family violence, that includes FGC, honor related violence and forced marriage. 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, the code prescribes to report the case to stop further bodily or mental harm.

In Dutch medical education diversity is given some attention. According to the Dutch framework for medical education (Laan et al., 2010) medical schools should prepare students to provide high quality care to socio-culturally diverse patients. Yet, an evaluation revealed that students learn that specific

diseases are related to ethnicity, and some attention is given to cultural differences in communication, but sociocultural issues remain mostly unaddressed (Muntinga et al., 2016).

In bioethics, but also in political theory, specific interventions related to HCPs are discussed. The focus of the debate is on the moral acceptability of the intervention. Often tolerance is preconditioned by autonomy (see for a review xxx, 2019). Daniel Engster for instance, discussing whether re-infibulation should be tolerated, argues that mentally competent women, who are able to make an informed choice, should not be forced to accept care and be allowed to care for themselves in whatever manner they choose. Hence, if they want to be re-infibulated, the request should be granted (2007, p. 106). We suspected that this literature would be of little help to GPs dealing with HCPs. Firstly, this type of argument ignores that people generally, and women experiencing HCPs in particular, live socially embedded lives, as feminist relational accounts of autonomy stress (Mackenzie & Stoljar 2000). They do not decide over their lives in a social vacuum. Restrictive socialization and oppressive family relationships may impact their decisions. Secondly, we expected that beside tolerance GPs might be concerned with other moral questions. Moreover, the empirical literature on the attitude of medical professionals towards hymen repair, a medical intervention that is related to HCPs that is empirically researched, shows that health professionals in Europe are quite divided over the issue. More than half of the public hospitals in Switzerland for instance accommodated requests for hymen repair (Tschudin et al., 2013). Gynecologists in the Netherlands by contrast generally (73%) said they would never perform a hymen repair (Van Lunsen and Van Moorst, 2012), while about half (52,5%) of the gynecologists in Belgium, who had received requests for a hymen repair, had agreed to do so (Heyerick and Van de Wiele, 2012: 30). We expected, therefore, that also GPs would react divided to other requests for help related to HCPs.

Methods

Participants and procedure

In the course of 2017, we conducted in-depth interviews with fourteen GPs. GPs are the gatekeepers to health care, which makes them well positioned to help women with health issues related to harmful practices. 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' (NHG Position paper, 2011). We choose for in-depth interviews, because these are best suited to explore the experiences and moral understandings of people (Green & Thorogood 2013). The GPs were recruited in collaboration with an academic hospital's GP specialty training, that has an extensive network of GPs. The hospital sent our call to the GPs and when they responded positively, we contacted them directly. Thus, we recruited nine participants, the other five we recruited through our personal network. As the GPs had to have experience with patients of immigrant background, we searched for GPs with a longer working experience and working in ethnically mixed neighborhoods and we aimed for some geographical

distribution. The average time the GPs are holding practice is twenty-three years with one GP holding practice for two years, and at the other end two GPs who had practiced for thirty-nine years and who had just retired at the time of the interview. 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. Nine 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, in ethnically mixed neighborhoods. Their patients of migrant background with needs related to HCPs were mainly people of Turkish or Moroccan background and people with a refugee background. Five participants hold practice in smaller towns. Their patients of migrant background were recruited for a nearby industry or a refugee center was established nearby.

Given the sensitivity of the subject, it matters how the subject is introduced to participants. The call was entitled 'Research General Practitioners on Requests for Help at the Intersection of Culture and Gender. How do you deal with emotionally charged themes like honor and virginity, homosexuality or forced marriage?' We explained that these were sensitive subjects, that already the terminology is contested. Practices like forced marriage and female genital cutting are sometimes named harmful cultural practices, whilst others prefer not to use this term because of the moral condemnation implicit in the term. (Nevertheless, one of the first GP's we interviewed said she had nearly refused to participate because of us using the term, which she found overly judgmental). We also explained that [first author] had in previous research met with young migrant women, who had needs related to these practices. Therefore, we were interested whether GPs had experiences with migrant women, who visit them with such problems and if so, how they deal with them. The framing of the subject as cases at the intersection of gender and culture and the example of homosexuality prompted the GPs to talk about broader issues than those traditionally associated with HCPs. We welcomed this however.

The topic list included background questions, like about the time they worked as GP and the neighborhood composition. We asked whether they had met with cases, like the ones mentioned in the call. We took the critiques on HCPs into account by including in our topic list comparative questions about GPs normal routine of advising patients in abusive relationships, or with a subject like marriage pressure, whether they also had male patients, who visited them with problems related to the subject. We also included questions about their responses to labiaplasty and male circumcision as arguably also harmful practices. 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.

Analysis

The interviews were transcribed and sent to the GPs for approval. Next, they were analyzed with the help of the software program Atlas-ti. In a first round we analyzed which HCPs the GPs encountered and coded them accordingly. We used a priori codes (Saldaña, 2013), based on known HCPs (e.g. honor related violence) and expanded these with new codes referring to other harmful practices that the GPs

mentioned as associated with cultural difference (e.g. family violence not honor related). Initially, we differentiated between arranged and forced marriage, and with that between voluntary and forced marriage. The distinction 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. The arranged marriages mentioned by the GP's also involved considerable pressure from the family, yet the GPs did not name them as forced. Therefore, we opted for a joint categorization under the term 'marriage pressure'. In a second round we focused on the GPs decisions regarding intervention and on their preceding considerations, thereby using process codes (this is text referring to action, Saldana, 2013; e.g. decision: invite parents for a conversation, consideration: wish patient). Thus, we reconstructed the GPs common way of responding to patients. In this second round of close-reading we found two main reasons why GPs are cautious to intervene in cases of HCPs. One is their reluctance to be culturally normative, the other is their understanding of patient's autonomy. Another theme that emerged is that in their wish to look after the well-being of the patient, some GPs took interventions that reached, as they well realized, the borders of their professional ethics. We will illustrate this by discussing their dealing with requests for virginity certificates. In the creation of new codes and 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 draft version of the paper was sent to all participants (respondent validation). We did not receive negative feedback; those GPs who responded said they had read it with interest.

Results

4.1 The GPs' Experiences with Harmful Cultural Practices

Table 1

	General practitioner														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
Marriage pressure	+	+	+	+	+	-	+	+	+	+	-	-	+	-	10
Family violence not honor related	+	+	+	+	+	-	-	+	-	-	-	-	+	+	8
Honor-related violence	+	+	+	+	+	+	+	+	+	+	-	-	-	-	10
Honor-related repudiation after rape	+	+	-	-	+	-	+	-	+	-	-	-	-	+	6
Virginity Certificate	+	+	+	+	+	-	+	-	+	-	+	-	+	+	10
Hymen 'repair'	-	+	+	+	+	-	-	-	+	+	-	+	-	-	6
Female Genital Cutting	-	+	+	+	+	+	+	+	+	+	-	-	+	+	11
Forced Abortion/give up the child	-	-	+	-	-	+	-	-	-	-	+	+	+	+	6
No control over own fertility	-	+	-	+	-	-	+	-	+	+	-	-	-	-	5
Non- acceptance of Homosexuality	-	+	-	-	-	-	-	-	-	-	-	-	+	+	3

Overview of the main cases mentioned by the GPs.

When mentioning female genital cutting the GPs meant they had adult patients in their practice who had been cut in their youth. The GPs were asked to treat physical complaints, like uterine infections, but otherwise did not have conversations with their patients about FGC, although some GPs tried. Some GPs suspected that the women avoided the subject, because they know that FGC is forbidden in the Netherlands, but it may also mean that the doctors have difficulty in addressing the subject in a way that does not scare the women, as is confirmed by other research (Allwood, 2017).

Ten GPs had patients who had experienced marriage pressure. For nine this included also patients who had successfully escaped an unwanted marriage, often by running away from home.

The background to honor related violence was that the victim was suspected of transgressing codes of proper female sexual conduct. The cases 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. When the interviews were done, GPs could refer patients to public hospitals and private clinics that perform hymen 'repair'. Since February 2020 hymen repair is discouraged in the Netherlands. Five GPs described cases in which married female patients had no control over their own fertility. They had no say in the use of contraceptives or the timing and number of pregnancies. Two GPs had male patients, who they suspected struggled with their homosexuality and one GP told about patients of hers, whose marriage had been arranged to, as she suspected, a homosexual man.

Beside the practices in the table, the GPs had encountered various other forms of harmful practices. Several GPs had had female patients who were send back against their will to the country of origin. Women came to surgery with psychosomatic complaints and depression. The underlying cause was in many cases that they were overly controlled by their family. Some examples that were given: GP4 had a Hindustani patient who was locked up in the house for three months by her husband. She discovered this because the woman did not show up at an appointment. GP6 had a Sri Lankan young woman among her patients who had tried to commit suicide, because she was not allowed to marry the man she loved. HP2 had a female patient who had caught a sexually transmitted disease (STD) from her husband but did not dare to confront him with that. A preliminary conclusion we can draw is that the majority of cases is related to the regulation of sexuality.

4.2 Interventions

4.2.1 Limited Space for Intervention

When patients come to them with social problems the GPs normal routine is to offer a listening ear and if patients are open to it give advice or organize help. This was also their course of action when patients explained to them their complaints related to harmful practices. Regularly, there was little room for intervention. Patients disappeared from their practice and only later they learned that a young woman was send back to the country of origin or was married to someone abroad or the patient would not disclose the cause of the medical complaint or accept intervention. Men, who the doctors suspected struggled with their homosexuality, were unwilling to discuss this. Women did not dare to leave a violent husband because of considerations regarding family honor. Illustrative is what GP2 related about a patient of hers of Turkish origin. 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's honor already so much by running away with a boyfriend, that she could not on top of that divorce. The GP had started conversations with the parents and the daughters. She had also suggested to call in social services, which they refused, but apparently, the family expected her to do more. Looking back at this case and others, she remarked: 'You see someone in need and there is nothing you can do. I find it the hardest to deal with that powerlessness. That is what I sometimes take home'.

4.2.2. Cultural Normativity and Intervention

GPs' interventions are also dependent on their willingness to be normative. This becomes clear from how the GPs deal with arranged marriages. GP13 always asks further when he suspects marriage pressure, but takes care not to sound judgmental. Thus, he regularly discovered that young women were going to get married, because of the pressure by the family, while they themselves did not want this marriage. About his own role he said: 'I always try to confirm them: "That as little as possible things happen to you, that you don't want to happen to you".' GP3, herself of Turkish origin, is more directive. She had a young man who came to consult her because he wanted to marry a woman whom the parents did not find acceptable. Later, she invited the parents for a conversation and told them: 'If he is happy with her... We live in 2016. You have to move with the times. You don't marry her, your son does.' GPs hence vary in their willingness to be normative and this impacts how they intervene. For majority-Dutch GPs decisions on intervention are complicated because they find it difficult to judge other cultures. Illustrative is GP13's attitude in an encounter with family violence in a Syrian refugee family. The husband was extremely violent and controlling. The wife was hardly allowed to leave the house. The GP discussed the case in the team - he works in a health center - and they decided to report the case to the complaints-office for family violence. Yet, the wife begged him 'literally on her knees', according to GP13, not do so. Eventually, the case was not reported. Looking back, the GP13's explanation is:

With Dutch families your conversation is more as equals. (I would say): "This just cannot be, if you don't want to listen, I am going to report it." Then I am harder. With this Syrian family I could not do this.

He suspected war trauma and very unequal gender relations and found it difficult to assess the consequences of reporting for the family. Hence, the cultural difference made him doubt about the right course of action.

Their attitude to refrain from moral judgment and from intervention when it concerns patients of migrant background sharply contrasts with their attitude towards Dutch patients, usually young women, who ask for labiaplasty. Then 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.

With male circumcision, which is in the Netherlands mainly practiced by Jews and Muslims, they are again not inclined to intervene. Male and female GPs felt that it is a practice that is so commonly accepted by their Islamic and Jewish patients that a conversation has no use, nor did they experience it themselves as a very controversial subject. Only GP3, herself of Turkish origin, was outspoken: 'It is ... a cultural thing, not a religious thing.' Still, she also said: 'It is so deeply rooted ... It is not open to discussion.' And so, she too, refrained from raising the subject with her patients.

4.2.3 Patients' Autonomy and Intervention

Another main reason why GPs may be cautious to intervene are considerations regarding their patients' autonomy. Illustrative is how they advise women of migrant background who are abused. Their common way of responding to family violence is to have a conversation with the patient and if she agrees, to invite the husband and call in other social services. For GP9 the limit is if the abuse is structural. In particular if there are children who witness the violence, she tries to steer women towards a divorce by cautiously asking 'Have you ever considered to divorce?' She has noticed that over the past twenty years a divorce has become more accepted in the Moroccan and Turkish communities and divorced women do not necessarily become social outcasts. Still, she said, she always tries to find out:

Is this on? (a divorce, xx/yy) Will you be able to get by on your own? The family of your husband will of course no longer accept you, but what if you are not accepted by your own family? Then you have a big problem as a divorced woman in this community, so (my advice) is dependent on the situation.

For similar reasons GP1 too is cautious to advise women with a migration background to leave their husband:

These women must in a short time-span develop a form of autonomy, they did not have before. They are raised as dependent wife and then, all of a sudden, they must continue on their own with their children, and cast out, often also by their own family and other people in their immediate environment. ... Sometimes, it is better to continue with a difficult husband.

At the same time, she said not to make a difference with native Dutch women: 'The same goes for them. You must not go faster than the person herself.' GP3 also takes into account the cultural background, but has different considerations:

This option of leaving is with Dutch people easier to discuss, the decision is easier to take. But I do discuss it, because they (migrant women, xx/yy) come to me for advice: "You can stay with him, but then realize that then probably nothing will change in your situation, or you can leave him, a divorce." I do not

take this decision, but I present you with the possibilities. O, that gives them something of a shock, because at that moment they had not yet considered that as a solution and they hear that from me, your GP ... Often, they also think: "But if I leave him, I have no house, no income, how about my children?" Because often, they also believe that if there is family violence, the children will be taken from them, that child protection services will be called in and the children be placed in care. They think: "I am dependent on him, so I have to stay with him." So, if you discuss this, it works clarifying. Yet, I always say: "It is your decision."

Hence, while the first two GPs believe that her cultural background may restrict a woman's capacity for autonomy, which makes them cautious to suggest women to leave their violent husband, the last GP, herself of Turkish origin, sees among the women lack of knowledge of their rights and of practical assistance available in the Netherlands, which makes them stay in an abusive marriage.

Yet, the GPs' restraint to intervene was also based on another consideration regarding autonomy. GPs generally felt intervention as an intrusion in other people's lives that was only justified if patients explicitly consented with or requested the intervention. As GP1 explained, with reference to a patient, who had been forced to marry and who visited her because she became depressive, and for whom she actually did intervene: 'It is a meddling in other people's lives, about which you ask yourself 'Is this my role? Do I know enough of it (their culture, xx/yy)?' Her general viewpoint is:

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. So, my idea is that one has to have patience and believe that the next generation will do it differently.

Another example is given by GP10. When women tell her that they do not want to become pregnant again, and if to discuss this with the husband is no option, she is willing to secretly provide contraceptives. Yet, she adds:

But I do not actively seek it out. In the end, I find it a matter of self-determination. People also have to choose or decide in this themselves. I understand that there are many hindrances, and that those barriers and hindrances are bigger than in Dutch culture, but still I believe that as GP it is not my task to play mothers and fathers for my patients. I work more demand-driven.

Even GP3, one of the doctors most prone to intervention, found it important to stress that it must be the patient, who decides.

4.2.4 Trespassing the Boundaries of Bioethics?

While the GPs were cautious to intervene if not requested by the patient, this is different when patients ask for help. Yet, this was not without moral dilemmas. This became most clear in the issue that the GPs experienced as the morally most trying, when they were asked to establish a patient's virginity. Ten GPs had received requests for virginity testing. 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. Four GPs have always complied with the request, two always refused and two have in the course of their practice changed position. The 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. Those who refused did so, because they did not consider this as part of their job or believed that by complying, they would strengthen the sexual morality they rejected. Of those who complied, some doctors had in some cases actually performed a vaginal examination, although they knew that 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 then to write a virginity certificate or if the family settled for that, to verbally transmit the result of the 'examination'. Yet, they found it problematic that they thus confirmed a sexual morality they rejected and helped keeping up the myth that all women have a hymen that bleeds upon first penetration. What bothered them professionally is 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 (2014) name them, as the double negation makes that technically they are not lying, but that did not ease their discomfort. GP1 explained: 'When it comes to virginity, you always do wrong, I find. Either you rape yourself, your values or norms, or you do violence to her, because she may be maltreated or lynched because she is not a virgin anymore.' GP3 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'. GP9 initially did not comply with requests for a virginity certificate. Yet, after she had witnessed what difficulties it caused for young women when their chastity was doubted, she changed her mind. One of her patients for instance was cast out by her family. GP4 on the other hand said that initially, without checking she 'declared anybody virgin, if this could keep them out of troubles.' Yet later, she noticed that a virginity certificate might pave the way to other undesirable things, like a marriage with a husband the young woman did not want (as the man demanded proof of his bride's virginity). She added: 'Then you think: "I can better not declare anything, because then she will not marry him, let there be disgrace in the family."' What bothered her also, was that she had young women in her practice, who were on the pill and of whom she knew they were not virgins, who still asked for a virginity certificate when they were about to marry. She explained her decision to no longer write virginity certificates by saying:

At a certain moment I realized that this is no longer my struggle, my war. If I can help you, by, say, walking in a protest march, I'll do that, and I am willing to explain [the hymen] to the community, I am willing to do anything, but this is not my war. You really have to do it yourself. It must really come from the inside.

Conclusions And Discussion

The GPs that were researched in this study had frequent encounters with patients, mostly women of migrant background, visiting them with needs related to HCPs. These were mostly related to the regulation of sexuality, like requests for virginity certificates, help with unwanted marriages, lack of control over their own fertility and honor related violence. While the GPs wanted to help these women in every way possible, regularly, 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. Still, in their desire to act in the best interest of the patient, some were willing to push the boundaries of their professional ethics, like when patients asked for a virginity certificate. The GPs were well aware that these patients had to fear serious harm if they were believed to have transgressed norms of proper sexual conduct. This is why some were willing to accommodate their request. This created the dilemma that they wanted to protect the patient, yet refrain from deceit. The cases presented by the GPs make clear that virginity testing and issuing virginity certificates, contra the view of the WHO that it is a harmful practice, can, depending on the context, prevent harm and fit into a personalized gender and culture sensitive healthcare, as also Crosby et al. (2020) argue.

A reason for GPs of native Dutch origin to refrain from intervention was because they were wary to judge other cultures. Also, some GPs assessed that because of their cultural upbringing women of migrant background might not be able to lead an autonomous life. That made them cautious to advise them to leave a violent husband. At the same time, it was also their respect for their patients' autonomy that restrained the GPs from intervening. Their line of conduct was to intervene only with the patient's explicit consent or upon the patient's concrete request. Hence, caution to judge other cultures, the assessment that a woman of migrant cultural background was not autonomous enough or the understanding of patient autonomy as intervention only upon a patient's request all resulted often in non-intervention. This is probably the answer to the question that motivated (the first author) to do this research, why the abuse that led women to attempt suicide could go on for so long.

The cases presented here raise the question whether cultural respect has led the native Dutch GPs to wrongfully withhold help. This is Unni Wikan's (2002) accusation against Norwegian social professionals. Yet, as the findings illustrate, for the Dutch GPs it was not so much cultural respect, but rather doubt, whether they were able to correctly assess, given the cultural circumstances, the consequences of their interventions, that made them wary to intervene. This finds support in the attitude of GP3, herself of Turkish origin, who in similar cases felt no restraint to speak her mind. The case of GP4, who stopped writing virginity certificates points to yet another possibility. She realized that she knew too little of what was going on in these families for her to oversee the consequences of her intervention. This links up with Pablo De Lora's (2015: 153) observation that 'the lack of the required knowledge to measure, estimate or understand those implications militate against turning physicians into social policy makers.' Hence, there are limits to what medical interventions can do to solve social inequalities. 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 and the limits of medical intervention.

Also, the GPs' responses to harmful practices raise difficult questions regarding autonomy. Do coercive cultural conditions impact the capacity for autonomy, as some GPs assumed? Or is explicit consent or a concrete request from the patient as a requirement for intervention, given the coercive conditions of their patients' lives, perhaps overdemanding? There certainly is a risk that the GPs wrongfully withheld help because they either under- or overestimated their patients' autonomy. Yet, this question can only be answered by contextual research that includes also the views and experiences of the women concerned.

The cases reported here also point to a theoretical omission. The increased importance of patient autonomy in medicine is to do justice to the person of the patient and act in accordance with her wishes. Therefore, current debates on autonomy in bioethics 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, like in the case of children, or no longer, like in the case of patients with severe dementia, able to full autonomy, hence to broaden the scope of autonomy (xxx 2019). Yet, the problem with HCPs is how doctors should act in case of cultural constraints on autonomy in mentally competent patients. Hence, the idea, central in bioethics, of patient autonomy, resting on an understanding of autonomy as a capacity all normal adults possess and can exercise, sits uneasily with the realities of patients with needs related to harmful practices. In feminist relational accounts of autonomy, it is broadly recognized that social relationships and socialization in restrictive cultural roles may hinder autonomy. Women may stay in an abusive marriage, because their capacity for critical reflection is affected by restrictive socialization and family relationships (Friedman 2003; Meyers 2000) or because after 'lifelong habituation' (Nussbaum 2001, p. 80) they believe this is women's fate. Feminist accounts of relational autonomy thus go a long way in explaining how cultural contexts may pose constraints on women's autonomy. Yet, the women in question are no cultural dupes, but as the experiences of the GPs suggest, negotiate their culture. We should orient our theoretical lens, therefore, not only on how cultural contexts constrain autonomy, but also on how choices are made within these cultural constraints (see also Foblets, Graziadei & Renteln 2018; Madhok, Phillips & Wilson 2013; Narayan 2001).

This study is, to the best of our knowledge, the first one that broadly investigated what health issues related to HCPs GPs encounter in their practice and how they deal with them. 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 patients are missing. More research is needed, among GPs and other health professionals, but in particular among the women concerned on their experiences with medical intervention related to HCPs. In future research it would be good also to compare more systematically than we were able to do between GPs' interventions in harmful practices among native majority patients and patients of migrant background.

The GPs that were interviewed were all very experienced doctors. Their accounts illustrate that even experienced doctors have difficulty in weighing the cultural context in their decision-making regarding

intervention in harmful practices. They may have over- or underestimated their patients' autonomy. Also, their wariness to intervene, caused by cultural doubt, may have caused them to have wrongfully withheld help. This calls for more attention in medical training on harmful practices and further reflection on autonomy under coercive cultural conditions and its implications for decisions on medical intervention.

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